

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13145 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13139

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN TB <u>5 Yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>526 Fort Avenue</u>		d. STREET ADDRESS <u>526 Fort Avenue</u>	
3. NAME OF DECEASED (Type or print) <u>Adeline</u>		4. DATE OF DEATH Month <u>December</u> Day <u>1</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 18, 1873</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>David Robbinett</u>		14. MOTHER'S MAIDEN NAME <u>Clyrenda Twigg</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Paul L. Alkire</u>		Address <u>Cumberland Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic C.V. disease</u> [a], stating the underlying cause last. DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Dec. 1, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/3/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Olive Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Oldtown Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth E. Silcox</u>		ADDRESS <u>Cumberland Maryland</u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	

1913

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

1913 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HYGIENIST

DEATH OF DEATH
A. 1913

MASSACHUSETTS

1913

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13146

CERTIFICATE OF DEATH

13140

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 7 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROBERT Middle PRESTON Last ANKENEY		4. DATE OF DEATH Month DECEMBER Day 4 Year 19 58.	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 13,
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 13 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CLAUDE ANKENY		14. MOTHER'S MAIDEN NAME CATHERINE SHUPP	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Palsy 351X DUE TO Lucie Brith, Donald Brith dying. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH from birth
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **Jan 28, 1958** to **Dec 4, 1958**, that I last saw the deceased alive on **Dec 4, 1958**, and that death occurred at **3:30 P. M.** from the causes and on the date stated above.

ACTUAL SIGNATURE **B. M. Schindler** M.D. ADDRESS (Street, city or town, State) **43 Gramet Ave. Berkeley Springs Md** DATE SIGNED **12/4/58**

PHYSICIAN'S NAME (Type) **DR. BLANE M. SCHINDLER**

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 7-	22c. NAME OF CEMETERY OR CREMATORY St Pauls Cemetery	22d. LOCATION (City, town, or county) (State) Rt 40 - near Clear Spring Md
23. FUNERAL DIRECTOR'S SIGNATURE C. E. Johnson		ADDRESS Berkeley Springs	24a. REC'D BY REGISTRAR DEC 9 '58
		24b. REGISTRAR'S SIGNATURE Arthur S. Hays	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1913

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

TIME

PLACE

CAUSE OF DEATH

DIAGNOSIS

REPORTED BY

SIGNATURE OF DECEASED

SIGNATURE OF WITNESSES

SIGNATURE OF PHYSICIAN

DATE OF BURIAL

TIME

PLACE

NAME OF BURIAL PLACE

NAME OF MINISTER

NAME OF CHURCH

NAME OF FUNERAL HOME

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF INTERVIEWER

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13141

13217 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>16 Uhl Street</u>		d. STREET ADDRESS <u>16 Uhl Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN R. ATKINSON</u>		4. DATE OF DEATH Month Day Year <u>Dec. 18, 19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 15, 1864</u>
9. AGE (In years last birthday) yrs. <u>94</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paymaster, Ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Hugh Atkinson</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Wallace</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Virgil E. Atkinson</u>		Address <u>Frostburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure - left side</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Cardiovascular disease</u> DUE TO <u>Atherosclerosis</u> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>year</u> <u>year</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 19 50</u> to <u>Dec 18 19 58</u> , that I last saw the deceased alive on <u>Dec 18 19 58</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Davis</u>		ADDRESS (Street, city or town, state) <u>2 Broadway, Frostburg, Md.</u>	
PHYSICIAN'S NAME (Type) <u>John B. Davis, M.D.</u>		DATE SIGNED <u>12/19/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 21, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Knight</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 23 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13226 CERTIFICATE OF DEATH

13142

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		c. LENGTH OF STAY IN 1b X Midland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lola B. Baker		4. DATE OF DEATH Month December Day 11 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 22, 1907 51
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) yrs. 51
11. BIRTHPLACE (State or foreign country) Barton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Clark		14. MOTHER'S MAIDEN NAME Molly Snyder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Thomas Baker		Address Midland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) "Husband" 154X DUE TO Metastatic carcinoma of liver and abdominal cavity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) adenocarcinoma of rectum. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Existed before February 1958.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from February 17, 19 58 to December 11, 19 58 , that I last saw the deceased alive on November 25, 19 58 , and that death occurred at 9:25 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 115 S. Centre Street DATE SIGNED			
ACTUAL SIGNATURE [Signature] M.D. 115 S. Centre Street			
PHYSICIAN'S NAME (Type) Dr. A. J. Mirkin		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/15/58	22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery	22d. LOCATION (City, town, or county) (State) Moscow, Md.
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	
24a. REC'D BY REGISTRAR DEC 15 '58		24b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G237 12-29-58 et

13218 CERTIFICATE OF DEATH

13143

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport, Md.		c. LENGTH OF STAY IN 1b 3 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kookon Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 West Vernport Cumberland	
f. STREET ADDRESS Walnut St.		g. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle E. Last Beach		4. DATE OF DEATH Month Dec. Day 16 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1880
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR: Months 78 Days 78 Hours 78 Min. 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Retired		10b. KIND OF BUSINESS OR INDUSTRY Tinplate Mill	
11. BIRTHPLACE (State or foreign country) Fairfax County, Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Worden Beach		14. MOTHER'S MAIDEN NAME Sarah unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mr. Lloyd Scheurling, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x Cardio Renal Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Generalized Arteriosclerosis DUE TO (c) 5yrs		INTERVAL BETWEEN ONSET AND DEATH 2yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 10 , 19 58 , to Dec 16 , 19 58 that I last saw the deceased alive on Dec 15 , 19 58 , and that death occurred at 2:30am , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 20 Green St Piedmont W Va DATE SIGNED			
ACTUAL SIGNATURE James H. Wolverton Sr M.D.			
PHYSICIAN'S NAME (Type) James H. Wolverton Sr Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-18-58	
22c. NAME OF CEMETERY OR CREMATORY Davis Memorial		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR DEC 22 58	
24b. REGISTRAR'S SIGNATURE Caroline L. Knecht			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13147

CERTIFICATE OF DEATH

13144

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN TB 5 HOURS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		d. STREET ADDRESS 1 15 PROSPECT SQUARE	
d. NAME OF HOSPITAL (If not in hospital, give place of death) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BABY GIRL BOLYARD		4. DATE OF DEATH Month DECEMBER Day 28 Year 19 58.	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 28, 1958
9. AGE (In years last birthday) yrs. 5		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 5 Days 5 Hours 5 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME RICHARD E. BOLYARD		14. MOTHER'S MAIDEN NAME HELEN S. SINCLAIR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 761.5 DUE TO Prematurely Central Placenta Previa Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hypofibrinogenemia (c) 5 hr. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5 hr.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 28, 1958 to Dec. 28, 1958 , that I last saw the deceased alive on Dec. 28, 1958 , and that death occurred at 8:13 P. M. from the causes and on the date stated above. W. R. Hodges ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 12/28/58			
ACTUAL SIGNATURE W. R. Hodges M.D. Cumberland, Md.			
PHYSICIAN'S NAME (Type) DR. W. R. HODGES			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/31/58	
22c. NAME OF CEMETERY OR CREMATORY Blumont Cemetery		22d. LOCATION (City, town, or county) (State) Grafton, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE DEC 30 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

CERTIFICATE OF DEATH

Form D-1, 1914

NAME OF DECEASED ALFRED A. BROWN SEX MALE AGE 45 YEARS

DATE OF DEATH 1914 PLACE OF DEATH HOME

CAUSE OF DEATH HEART DISEASE

DATE OF BIRTH 1869 PLACE OF BIRTH NEW YORK

EDUCATION HIGH SCHOOL OCCUPATION CLERK

RELIGION METHODIST MARRIED YES

WIFE'S NAME MARY A. BROWN DECEASED'S NAME ALFRED A. BROWN

DECEASED'S ADDRESS 1234 N. EIGHTH ST. BALTIMORE, MD.

DECEASED'S OCCUPATION CLERK DECEASED'S RELIGION METHODIST

DECEASED'S DATE OF BIRTH 1869 DECEASED'S PLACE OF BIRTH NEW YORK

DECEASED'S EDUCATION HIGH SCHOOL DECEASED'S OCCUPATION CLERK

DECEASED'S RELIGION METHODIST DECEASED'S MARRIED YES

DECEASED'S WIFE'S NAME MARY A. BROWN DECEASED'S NAME ALFRED A. BROWN

DECEASED'S ADDRESS 1234 N. EIGHTH ST. BALTIMORE, MD.

DECEASED'S OCCUPATION CLERK DECEASED'S RELIGION METHODIST

DECEASED'S DATE OF BIRTH 1869 DECEASED'S PLACE OF BIRTH NEW YORK

DECEASED'S EDUCATION HIGH SCHOOL DECEASED'S OCCUPATION CLERK

DECEASED'S RELIGION METHODIST DECEASED'S MARRIED YES

DECEASED'S WIFE'S NAME MARY A. BROWN DECEASED'S NAME ALFRED A. BROWN

DECEASED'S ADDRESS 1234 N. EIGHTH ST. BALTIMORE, MD.

DECEASED'S OCCUPATION CLERK DECEASED'S RELIGION METHODIST

DECEASED'S DATE OF BIRTH 1869 DECEASED'S PLACE OF BIRTH NEW YORK

DECEASED'S EDUCATION HIGH SCHOOL DECEASED'S OCCUPATION CLERK

DECEASED'S RELIGION METHODIST DECEASED'S MARRIED YES

DECEASED'S WIFE'S NAME MARY A. BROWN DECEASED'S NAME ALFRED A. BROWN

DECEASED'S ADDRESS 1234 N. EIGHTH ST. BALTIMORE, MD.

DECEASED'S OCCUPATION CLERK DECEASED'S RELIGION METHODIST

DECEASED'S DATE OF BIRTH 1869 DECEASED'S PLACE OF BIRTH NEW YORK

DECEASED'S EDUCATION HIGH SCHOOL DECEASED'S OCCUPATION CLERK

DECEASED'S RELIGION METHODIST DECEASED'S MARRIED YES

DECEASED'S WIFE'S NAME MARY A. BROWN DECEASED'S NAME ALFRED A. BROWN

DECEASED'S ADDRESS 1234 N. EIGHTH ST. BALTIMORE, MD.

DECEASED'S OCCUPATION CLERK DECEASED'S RELIGION METHODIST

DECEASED'S DATE OF BIRTH 1869 DECEASED'S PLACE OF BIRTH NEW YORK

DECEASED'S EDUCATION HIGH SCHOOL DECEASED'S OCCUPATION CLERK

DECEASED'S RELIGION METHODIST DECEASED'S MARRIED YES

DECEASED'S WIFE'S NAME MARY A. BROWN DECEASED'S NAME ALFRED A. BROWN

DECEASED'S ADDRESS 1234 N. EIGHTH ST. BALTIMORE, MD.

DECEASED'S OCCUPATION CLERK DECEASED'S RELIGION METHODIST

DECEASED'S DATE OF BIRTH 1869 DECEASED'S PLACE OF BIRTH NEW YORK

DECEASED'S EDUCATION HIGH SCHOOL DECEASED'S OCCUPATION CLERK

DECEASED'S RELIGION METHODIST DECEASED'S MARRIED YES

DECEASED'S WIFE'S NAME MARY A. BROWN DECEASED'S NAME ALFRED A. BROWN

DECEASED'S ADDRESS 1234 N. EIGHTH ST. BALTIMORE, MD.

13148 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 30 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) WARWICK AND MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle B Last BOYD				4. DATE OF DEATH Month DECEMBER Day 31 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 18 1894	
9. AGE (In years last birthday) yrs. 64		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Painter		11. BIRTHPLACE (State or foreign country) MARYLAND -HANCOCK		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WALTER BOYD				14. MOTHER'S MAIDEN NAME HATTIE COOFFMAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) yes War I				16. SOCIAL SECURITY NO. 214-07-3802		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/1 , 19 58 , to 1/31 , 19 59 , that I last saw the deceased alive on 1/31 , 19 59 , and that death occurred at 2:35 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 456 N. Center St DATE SIGNED 1/3/59 ACTUAL SIGNATURE Leo H. Ley Jr. M.D. 456 N. Center St PHYSICIAN'S NAME (Type) LEO H. LEY JR. Cumberland Ind							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-3-59		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR DATE JAN 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film 236 12-19-58 ams

13149 CERTIFICATE OF DEATH

13149

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 18 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WARWICK AND MEMORIAL HOSPITAL-MEMORIAL AVE.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND 02 d. STREET ADDRESS 304 PENNSYLVANIA AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LESTER Bryan		4. DATE OF DEATH Month DECEMBER 11 Day 19 Year 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 21, 1896
9. AGE (In years from birthday) yrs. 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith helper	
11. BIRTHPLACE (State or foreign country) MELROSE PARK, ILL.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME THOMAS BURDETT		14. MOTHER'S MAIDEN NAME ISABELLE CRAWFORD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL	
17. INFORMANT CUMBERLAND, MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinomatous DUE TO Original site undetermined (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 10 days 4 min	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 10, 1958 , to Dec. 11, 1958 , that I last saw the deceased alive on Dec. 10, 1958 , and that death occurred at 4:05 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Clay Durrett		ADDRESS (Street, city or town, state) 236 1/2 E. Cumberland	
PHYSICIAN'S NAME (Type) DR. CLAY DURRETT		DATE SIGNED 12/11/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 15, 1958	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, Cumberland, Md.		24a. REC'D BY REGISTRAR DEC 15 '58	
		24b. REGISTRAR'S SIGNATURE Arthur E. Kline	

CERTIFICATE OF DEATH

REGISTRATION

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF BURIAL

DATE OF BURIAL

TIME OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

TIME OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

TIME OF CREMATION

PLACE OF CREMATION

DATE OF REINTERMENT

TIME OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

TIME OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

TIME OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

TIME OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

TIME OF REINTERMENT

PLACE OF REINTERMENT

DATE OF REINTERMENT

TIME OF REINTERMENT

PLACE OF REINTERMENT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13150 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13147

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>2 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>630 Hill Top Drive</u>		d. STREET ADDRESS <u>630 Hill Top Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Raymond</u> Last <u>Chapline</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>4,</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 12, 1885</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal Service</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William A. Chapline</u>		14. MOTHER'S MAIDEN NAME <u>Ida Cookus</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. J. L. Mathews</u>		Address <u>Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Sclerosis</u> (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>-----</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Dec. 4, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 6, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Shepherdstown, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

FOR STATE
HEALTH DEPT.



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE
MARIJUANA ACT, 1937, AND THE
NARCOTICS ACT, 1937, AND THE
PSYCHOTROPIC DRUGS ACT, 1964.
IT IS NOT VALID FOR THE PURPOSES OF THE
MARIJUANA ACT, 1937, AND THE
NARCOTICS ACT, 1937, AND THE
PSYCHOTROPIC DRUGS ACT, 1964, IF
IT IS USED FOR ANY OTHER PURPOSE.
IT IS NOT VALID FOR THE PURPOSES OF THE
MARIJUANA ACT, 1937, AND THE
NARCOTICS ACT, 1937, AND THE
PSYCHOTROPIC DRUGS ACT, 1964, IF
IT IS USED FOR ANY OTHER PURPOSE.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
18150 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME (Last, First, Middle Initial) JAMES E. ROSS		DATE OF BIRTH 10/15/1915	SEX Male
OCCUPATION Salesman		EDUCATION High School	RELIGION Roman Catholic
PLACE OF BIRTH Baltimore, Md.		DATE OF DEATH 10/25/1964	TIME OF DEATH 10:30 AM
CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural	
DETAILS OF ILLNESS The decedent was a well-known and well-liked member of the community. He had been in good health until about one month before his death, when he began to experience chest pain and shortness of breath. He was treated by his family physician, who advised him to rest and take aspirin. The symptoms continued to worsen, and he was eventually admitted to the hospital. He died on October 25, 1964, at the age of 49 years.			
SIGNATURE OF MEDICAL EXAMINER J. E. ROSS, M.D.			
DATE 10/25/1964			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13148

13151 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>			c. LENGTH OF STAY IN 1b <u>2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>516 Riehl Avenue</u>				d. STREET ADDRESS <u>516 Riehl Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helena</u> Middle <u>M.</u> Last <u>Close</u>				4. DATE OF DEATH Month <u>December</u> Day <u>18</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-13-1877</u>	
9. AGE (In years lost birthday) <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Frostburg, Md.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Frostburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Brode</u>				14. MOTHER'S MAIDEN NAME <u>Wilhelminia Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Cumberland, Md.</u> <u>Mrs. John Krailing, 516 Riehl Ave.,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>macrocytic anemia, Cause undet.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>18 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1940</u> , 19 <u>40</u> , to <u>18 Dec</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>15 Dec</u> , 19 <u>58</u> , and that death occurred at <u>6 A.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. Alfred Van Ormer</u> M.D.				ADDRESS (Street, city or town, state) <u>122 S Center St. Cumberland Md.</u>			
PHYSICIAN'S NAME (Type) <u>W. Alfred Van Ormer, M. D.</u>				DATE SIGNED <u>18 Dec 58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-20-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park Frostburg Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Haier Funeral Home</u> <u>Burial H. Winters</u> 23 E. Main, Frostburg, Md.				24a. REC'D BY REGISTRAR <u>DATE 12-20-58</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND AND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13227

1 Item 6 Film 6237 1-5-59 et
CERTIFICATE OF DEATH

13149

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Vale Md.				c. LENGTH OF STAY IN 1b 15 Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Rebecca Middle Cook Last Cook				4. DATE OF DEATH Month 12 Day 16 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 14, 1863	
9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR: Months 95 Days 95 Hours 95 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Hyndman, Pa.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Lowery				14. MOTHER'S MAIDEN NAME Lydia Sheirer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none			
17. INFORMANT John R. Cook				Address LaVale MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) ? INTERVAL BETWEEN ONSET AND DEATH 24 hrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb 7, 1957 to Dec 16, 1958 that I last saw the deceased alive on 12-9 , 19 58 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE William P. Jones M.D. 4411 Centre St 12-14-58							
PHYSICIAN'S NAME (Type) William P. Jones Cumberland md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-19-58		22c. NAME OF CEMETERY OR CREMATORY Cooks Mills Cemetery		22d. LOCATION (City, town, or county) (State) Hyndman, Pa. RD#1 Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Zeigler				ADDRESS Hyndman, Pa.		24a. REC'D BY REGISTRAR DATE DEC 29 '58	
				24b. REGISTRAR'S SIGNATURE W. H. H. H.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 See: Birth Cert. et

13152

CERTIFICATE OF DEATH

13150

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Morgan			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 5 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Paw Paw 85 X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.				d. STREET ADDRESS ---		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last CORBETT				4. DATE OF DEATH Month December Day 30 Year 19 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DECEMBER 30, 1958	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months		Days		Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.	
13. FATHER'S NAME ROBERT E. CORBETT				14. MOTHER'S MAIDEN NAME BEVERLY JANE HERRELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 776X IMMEDIATE CAUSE (a) Prematurity (16 wks) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from Dec. 30, 1958 to Dec 30, 1958 , that I last saw the deceased alive on Dec 30, 1958 , and that death occurred at 235 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE W. Wake Hedges ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 1/23/58 PHYSICIAN'S NAME (Type) _____ 22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 22b. DATE THEREOF 12-31-58 22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital 22d. LOCATION (City, town, or county) (State) Cumberland, Maryland 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR JAN 2 '59 24b. REGISTRAR'S SIGNATURE Arthur S. Hanks							

CERTIFICATE OF DEATH

REG. NO. 11714

DEATH NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13153

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 Film 236 12-12-58 et

13151

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	c. LENGTH OF STAY in 1b <u>5 weeks</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hosp. 11907777</u> <u>JEFF</u>		d. STREET ADDRESS <u>404 Hill Street</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Donette</u> <u>Jean</u> <u>Crabtree</u>	4. DATE OF DEATH Month <u>Dec.</u> Day <u>5</u> Year <u>1958</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 30/58</u>
9. AGE (In years last birthday) yrs. <u>1</u> Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Thomas Crabtree</u>		14. MOTHER'S MAIDEN NAME <u>Carolyn Sills</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Carolyn Crabtree, Cumberland, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> <u>7547</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Stenosis,</u> DUE TO (c) <u>Congenital</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Dec. 5, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 8 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u>		ADDRESS <u>Cumberland Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraw</u>	

2060 233 XV5

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO JUDGE OF THE CAUSE OF DEATH. IT IS TO BE SIGNED AND DATED BY THE EXAMINER, AND THE CAUSE OF DEATH IS TO BE STATED IN FULL. THE NAME OF THE DECEASED IS TO BE WRITTEN IN FULL, AND THE PLACE OF BIRTH IS TO BE STATED. THE DATE OF BIRTH IS TO BE STATED. THE SEX IS TO BE STATED. THE OCCUPATION IS TO BE STATED. THE MANNER OF DEATH IS TO BE STATED. THE CAUSE OF DEATH IS TO BE STATED. THE PLACE OF DEATH IS TO BE STATED. THE TIME OF DEATH IS TO BE STATED. THE SIGNATURE OF THE EXAMINER IS TO BE STATED. THE DATE OF EXAMINATION IS TO BE STATED. THE NAME OF THE HOSPITAL OR CLINIC IS TO BE STATED. THE NAME OF THE CITY OR TOWN IS TO BE STATED. THE NAME OF THE COUNTY IS TO BE STATED. THE NAME OF THE STATE IS TO BE STATED.

18153 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

NAME OF DECEASED		DATE OF DEATH	
PLACE OF BIRTH		DATE OF BIRTH	
SEX		OCCUPATION	
MANNER OF DEATH		CAUSE OF DEATH	
PLACE OF DEATH		TIME OF DEATH	
SIGNATURE OF EXAMINER		DATE OF EXAMINATION	
NAME OF HOSPITAL OR CLINIC		NAME OF CITY OR TOWN	
NAME OF COUNTY		NAME OF STATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13152

13154 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE MARYIA ND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 10 HOURS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				d. STREET ADDRESS 122 INDEPENDENCE ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle DENISE Last CREEGAN				4. DATE OF DEATH Month DECEMBER Day 28 Year 19 58			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 28, 1958	
9. AGE (In years last birthday) 4		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) Months 4 Days 4 Hours 4 Min. 4	
11. BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME PAUL CREEGAN				14. MOTHER'S MAIDEN NAME MARY ANN POWERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT PATIENT'S CHART			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 493X DUE TO premature labor Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2 days DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. Immature baby, stage pneumonia at 4w. Over ventilation, anemia				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from August 28, 1958 , to December 28, 1958 , that I last saw the deceased alive on December 28, 1958 , and that death occurred at 10:55 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Elizabeth Brings		M.D. 55 Greene St. Cumberland		DATE SIGNED 12/29/58			
PHYSICIAN'S NAME (Type) Elizabeth Brings, M.D.		ADDRESS 55 Greene St., Cumberland, MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/31/58		22c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul		22d. LOCATION (City, town, or county) (State) Cumberland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				ADDRESS Cumberland Maryland		24a. REC'D BY REGISTRAR DATE JAN 2 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hays			

2060221XV3

1915

MASSACHUSETTS DEPARTMENT OF HEALTH-BATHING 18

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		Signature of Physician		Signature of Registrar	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13228 CERTIFICATE OF DEATH

13153

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LA VALE</u>			c. LENGTH OF STAY IN 1b <u>18 YEARS</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X LA VALE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>510 NATIONAL HIGHWAY</u>				d. STREET ADDRESS <u>1510 NATIONAL HIGHWAY</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>EMMA</u>		First Middle Last <u>J. DANNACKER</u>		4. DATE OF DEATH Month <u>DEC</u> Day <u>27</u> Year <u>1958</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 10, 1873</u>		9. AGE (In years lost birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>JOHNSTOWN, PA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN W. WHITFORD</u>				14. MOTHER'S MAIDEN NAME <u>MARY JANE JENKINS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Bess D. Dannacker</u>		Address <u>510 National Hwy, LaVal, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1940</u> , 19 <u>58</u> , to <u>DEC 27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec - 25</u> , 19 <u>58</u> , and that death occurred at <u>3:00 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>L. B. Matthews M.D.</u>				M.D. <u>49 Green St</u>			
PHYSICIAN'S NAME (Type) <u>L. B. Matthews M.D.</u>				<u>Camdenland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>DEC 30, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>UNION CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MEYERSDALE SOMERSET, PA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. C. Strick</u>				ADDRESS <u>Meyersdale Pa</u>		24a. RECEIVED BY REGISTRAR DATE <u>DEC 30 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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13155

13154

Reg. Dist. No.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13155 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 212 Washington St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SARAH Middle EDITH Last DAWSON		4. DATE OF DEATH Month Dec. Day 30, Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1888
9. AGE (In years last birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Bedford, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George B. Milburn		14. MOTHER'S MAIDEN NAME Sue Biddle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No, (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Edgar J. Dawson		Address 212 Washington St., Cumb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Generalized arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 years DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 3 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-27-1958 to 12-27-1958 , that I last saw the deceased alive on 12-27-1958 , and that death occurred at 11:47 A. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. James T. Johnson M.D.		ADDRESS (Street, city or town, state) 16 Greene St., Cumberland, Md.	
DATE SIGNED 12-31-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/1/1959	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Mausoleum	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR DATE JAN 5 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

Item 1 Film G236 12-10-58 et

13219 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN IB <u>10 Yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At home -- 23 Centennial Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Frank</u>		4. DATE OF DEATH Month <u>December</u> Day <u>1st</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 14th, 1887</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer-Street dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City of Fbg.</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Dietle</u>		14. MOTHER'S MAIDEN NAME <u>Christiana Nedro</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u>215-26-9344</u>	
17. INFORMANT <u>Mrs. Clara R. Dietle, Frostburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> (c) <u>Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 15, 1958</u> to <u>Dec. 1, 1958</u> that I last saw the deceased alive on <u>Dec. 1, 1958</u> , and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John B. Davis</u>		ADDRESS (Street, city or town, state) <u>2 Broadway, Frostburg, Md.</u>	
PHYSICIAN'S NAME (Type) <u>John B. Davis, M.D.</u>		DATE SIGNED <u>12/2/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-3-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pocahontas, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst,</u>		ADDRESS <u>Frostburg, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 4 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

FILE NO.

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. TIME OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. CAUSE OF DEATH</p>		<p>10. MANNER OF DEATH</p>	
<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. SIGNATURE OF WITNESSES</p>		<p>14. SIGNATURE OF DECEASED</p>	
<p>15. SIGNATURE OF FUNERAL HOME</p>		<p>16. SIGNATURE OF BURIAL PLACE</p>	
<p>17. SIGNATURE OF CEMETERY</p>		<p>18. SIGNATURE OF INTERVIEWER</p>	
<p>19. SIGNATURE OF INTERVIEWER</p>		<p>20. SIGNATURE OF INTERVIEWER</p>	
<p>21. SIGNATURE OF INTERVIEWER</p>		<p>22. SIGNATURE OF INTERVIEWER</p>	
<p>23. SIGNATURE OF INTERVIEWER</p>		<p>24. SIGNATURE OF INTERVIEWER</p>	
<p>25. SIGNATURE OF INTERVIEWER</p>		<p>26. SIGNATURE OF INTERVIEWER</p>	
<p>27. SIGNATURE OF INTERVIEWER</p>		<p>28. SIGNATURE OF INTERVIEWER</p>	
<p>29. SIGNATURE OF INTERVIEWER</p>		<p>30. SIGNATURE OF INTERVIEWER</p>	
<p>31. SIGNATURE OF INTERVIEWER</p>		<p>32. SIGNATURE OF INTERVIEWER</p>	
<p>33. SIGNATURE OF INTERVIEWER</p>		<p>34. SIGNATURE OF INTERVIEWER</p>	
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<p>37. SIGNATURE OF INTERVIEWER</p>		<p>38. SIGNATURE OF INTERVIEWER</p>	
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<p>41. SIGNATURE OF INTERVIEWER</p>		<p>42. SIGNATURE OF INTERVIEWER</p>	
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<p>69. SIGNATURE OF INTERVIEWER</p>		<p>70. SIGNATURE OF INTERVIEWER</p>	
<p>71. SIGNATURE OF INTERVIEWER</p>		<p>72. SIGNATURE OF INTERVIEWER</p>	
<p>73. SIGNATURE OF INTERVIEWER</p>		<p>74. SIGNATURE OF INTERVIEWER</p>	
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<p>77. SIGNATURE OF INTERVIEWER</p>		<p>78. SIGNATURE OF INTERVIEWER</p>	
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<p>81. SIGNATURE OF INTERVIEWER</p>		<p>82. SIGNATURE OF INTERVIEWER</p>	
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<p>97. SIGNATURE OF INTERVIEWER</p>		<p>98. SIGNATURE OF INTERVIEWER</p>	
<p>99. SIGNATURE OF INTERVIEWER</p>		<p>100. SIGNATURE OF INTERVIEWER</p>	

THIS IS A COPY OF THE ORIGINAL RECORD OF THE DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 236 12/19/58 ams DR. REITER		MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Items 11, 12 Film G236 12-17-58 et 13156 CERTIFICATE OF DEATH		13156	
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 2 HRS-25 MIN. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL-MEMORIAL AVENUE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTERNPORT d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		Reg. Dist. No.	
3. NAME OF DECEASED (Type or print) First HARRY Middle DOHM Last DOHM		4. DATE OF DEATH Month 12 Day 9 Year 19 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH SEPT. 19		9. AGE (In years last birthday) 9 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME HARRY E. DOHM		14. MOTHER'S MAIDEN NAME CAROLYN GWYNN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia and 082.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) cerebral edema due to viral encephalitis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral edema		INTERVAL BETWEEN ONSET AND DEATH 1 day		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Dec 9, 1958 , to Dec 9, 1958 , that I last saw the deceased alive on Dec 9, 1958 , and that death occurred at 5:25 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE R. A. Reiter		ADDRESS (Street, city or town, state) 112 Bedford St., Cumberland Md., 21513 DATE SIGNED Dec 11 '58			
PHYSICIAN'S NAME (Type) DR. REITER					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/11/58		22c. NAME OF CEMETERY OR CREMATORY Philop	
22d. LOCATION (City, town, or county) (State) Westernport Md.		23. FUNERAL DIRECTOR'S SIGNATURE E. S. Bral		ADDRESS Westernport, Md.	
24a. REC'D BY REGISTRAR DEC 11 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Knaus			

13157 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 11 HRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONA CONING		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS 20 FURNACE STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES WILLIAM Middle DUCKWORTH Last DUCKWORTH				4. DATE OF DEATH Month DECEMBER Day 6 Year 1958			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 7-1878		9. AGE (In years last birthday) yrs. 80	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) LONA CONING, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE DUCKWORTH				14. MOTHER'S MAIDEN NAME CLEMENTINE PEARCE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage with its Complications DUE TO Hypertensive Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 15 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 Dec, 1958 , to 6 Dec, 1958 , that I last saw the deceased alive on 5 Dec, 1958 , 19____, and that death occurred at 11:00AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Alfred Van Ormer M.D.				ADDRESS (Street, city or town, state) 122 S. Centre St. Cumberland, Md.		DATE SIGNED 6 Dec 58	
PHYSICIAN'S NAME (Type) W. A. VAN ORMER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-9-58		22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. L. Boal-Westernport, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE DEC 9 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Krawe			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE 18

18187

<p>1. NAME OF DECEASED</p> <p>JOHN J. SMITH</p>		<p>2. SEX</p> <p>MALE</p>	
<p>3. AGE</p> <p>45</p>		<p>4. DATE OF BIRTH</p> <p>1873</p>	
<p>5. PLACE OF BIRTH</p> <p>NEW YORK</p>		<p>6. OCCUPATION</p> <p>LABORER</p>	
<p>7. MARITAL STATUS</p> <p>MARRIED</p>		<p>8. DATE OF DEATH</p> <p>1918</p>	
<p>9. PLACE OF DEATH</p> <p>HOME</p>		<p>10. CAUSE OF DEATH</p> <p>HEART DISEASE</p>	
<p>11. SIGNATURE OF PHYSICIAN</p> <p>[Signature]</p>		<p>12. SIGNATURE OF REGISTRAR</p> <p>[Signature]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13158 CERTIFICATE OF DEATH

13158

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 5 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WARWICK AND MEMORIAL HOSPITAL—MEMORIAL AVE.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FLINTSTONE d. STREET ADDRESS Green Ridge Forestry Camp e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WAYNARD Middle Oroscoe Last FEDERLINE			4. DATE OF DEATH Month DECEMBER Day 22 Year 19 58				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-22-1899	9. AGE (In years last birthday) yrs. 59	IF UNDER 1 YEAR Months 59 Days 59 Hours 59 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director		10b. KIND OF BUSINESS OR INDUSTRY State Training School		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA			
13. FATHER'S NAME JOHN R. FEDERLINE			14. MOTHER'S MAIDEN NAME MARY SLATER				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes,		16. SOCIAL SECURITY NO. 247-05-1416		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X DUE TO Chronic Nephritis and Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Myocardial Disease DUE TO (c) Chronic Nephritis and INTERVAL BETWEEN ONSET AND DEATH 78 hrs. 6 months							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 19			
20f. (City or town) 19		20g. (County) 19		20h. (State) 19			
21. I certify that I attended the deceased from 7/2/58 , 19 58 , to 12/22/58 , 19 58 , that I last saw the deceased alive on 12/22/58 , 19 58 , and that death occurred at 9:50 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 12/22/58							
ACTUAL SIGNATURE DR. RICHARD J. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/26/58		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park			
22d. LOCATION (City, town, or county) Spartanburg, So. Carolina		23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George ADDRESS Cumberland, Md.					
24a. REC'D BY REGISTRAR DATE DEC 29 58		24b. REGISTRAR'S SIGNATURE Arthur L. Kline					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13229

CERTIFICATE OF DEATH

13159

Items 1, 3, 11, 12, 15-28 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oldtown</u>		c. LENGTH OF STAY IN lb <u>1 Yr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>"Daughter's home"</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Isabelle</u> First <u>Keefe</u> Middle <u>Felker</u>		4. DATE OF DEATH <u>December 6th, 1958</u> Month <u>December</u> Day <u>6th</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1st, 1874</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR <u>Months</u> Days <u>Hours</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Conrad Keefer</u>		14. MOTHER'S MAIDEN NAME <u>Cordelia Bittner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Maggie Leasure, Oldtown, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GASTRO-ENTERITIS</u> <u>571.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>HEART DISEASE-</u> DUE TO (c) <u>ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>6 months</u> <u>"</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x DIABETES MELLITUS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1st, 1958</u> to <u>June 6th, 1958</u> , that I last saw the deceased alive on <u>10/31</u> , 19 <u>58</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>12/8/58</u>	
PHYSICIAN'S NAME (Type) <u>S & WEISMAN MD</u>		ADDRESS <u>Cumberland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-9-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>White Oak Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Somerset County Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst, Frostburg, Md.</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u> </u>	
DATE <u>DEC 10 '58</u>		DATE <u> </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13228

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

WIN BOND

DEATH OF

NAME OF DECEASED

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF BURIAL

NAME OF CREMATION

NAME OF INCINERATION

NAME OF DISPOSITION

NAME OF REMAINS

NAME OF BONES

NAME OF TEETH

NAME OF HAIR

NAME OF SKIN

NAME OF FINGER

NAME OF TOE

NAME OF NAIL

13230 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Morantown, Frostburg</u>		c. LENGTH OF STAY IN 1b <u>50 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Morantown, Frostburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nazzareno</u> Middle <u>Femi</u> Last <u>Femi</u>			4. DATE OF DEATH Month <u>December</u> Day <u>1st</u> Year <u>1958</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 29th, 1884</u>		9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>	
13. FATHER'S NAME <u>Santino Femi</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-20-5383</u>		17. INFORMANT <u>Ted Femi, LaVale, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Cerebral Thrombosis</u> DUE TO (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u>years</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>Dec 14</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Dec 1</u> , 19 <u>58</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2 Broadway, Frostburg, Md.</u> DATE SIGNED <u>12/4/58</u>							
ACTUAL SIGNATURE <u>John B. Davis</u>		M.D. <u>John B. Davis, M.D.</u>					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-4-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst, Frostburg, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>DEC 4 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur J. Kane</u>			

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS A15 (4)
ISM 10/57

13159 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland, b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland, Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS 307 Pulaski Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Wilbert Middle Edward Last Firlie		4. DATE OF DEATH Month Dec. Day 20, Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 19, 1907
9. AGE (In years last birthday) yrs. 51		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prop. Bowling Alley		10b. KIND OF BUSINESS OR INDUSTRY Part Owner	
11. BIRTHPLACE (State or foreign country) Midland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter V. Firlie		14. MOTHER'S MAIDEN NAME Margaret Dugan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Dolores C. Firlie Cumberland, Md.	
17. INFORMANT Dolores C. Firlie Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Esophageal Varices 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cirrhosis of the liver (c) and other conditions multiple abscesses of kidneys		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebroiditis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1 Nov. 1958 to 20 Dec. 1958 , that I last saw the deceased alive on 20 Dec. 1958 , and that death occurred at 2:40 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ben Weisman		ADDRESS (Street, city or town, state) 59 GREENE ST	
PHYSICIAN'S NAME (Type) S. G. WEISMAN M.D.		DATE SIGNED 12/20/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-23-58	
22c. NAME OF CEMETERY OR CREMATORY ST. Peter & Paul Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DEC 23 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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12159 - CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of funeral director	
13. Signature of undertaker		14. Signature of cemetery		15. Signature of burial place		16. Signature of interment	
17. Signature of burial place		18. Signature of interment		19. Signature of burial place		20. Signature of interment	
21. Signature of burial place		22. Signature of interment		23. Signature of burial place		24. Signature of interment	
25. Signature of burial place		26. Signature of interment		27. Signature of burial place		28. Signature of interment	
29. Signature of burial place		30. Signature of interment		31. Signature of burial place		32. Signature of interment	
33. Signature of burial place		34. Signature of interment		35. Signature of burial place		36. Signature of interment	
37. Signature of burial place		38. Signature of interment		39. Signature of burial place		40. Signature of interment	
41. Signature of burial place		42. Signature of interment		43. Signature of burial place		44. Signature of interment	
45. Signature of burial place		46. Signature of interment		47. Signature of burial place		48. Signature of interment	
49. Signature of burial place		50. Signature of interment		51. Signature of burial place		52. Signature of interment	
53. Signature of burial place		54. Signature of interment		55. Signature of burial place		56. Signature of interment	
57. Signature of burial place		58. Signature of interment		59. Signature of burial place		60. Signature of interment	
61. Signature of burial place		62. Signature of interment		63. Signature of burial place		64. Signature of interment	
65. Signature of burial place		66. Signature of interment		67. Signature of burial place		68. Signature of interment	
69. Signature of burial place		70. Signature of interment		71. Signature of burial place		72. Signature of interment	
73. Signature of burial place		74. Signature of interment		75. Signature of burial place		76. Signature of interment	
77. Signature of burial place		78. Signature of interment		79. Signature of burial place		80. Signature of interment	
81. Signature of burial place		82. Signature of interment		83. Signature of burial place		84. Signature of interment	
85. Signature of burial place		86. Signature of interment		87. Signature of burial place		88. Signature of interment	
89. Signature of burial place		90. Signature of interment		91. Signature of burial place		92. Signature of interment	
93. Signature of burial place		94. Signature of interment		95. Signature of burial place		96. Signature of interment	
97. Signature of burial place		98. Signature of interment		99. Signature of burial place		100. Signature of interment	

**FOR STATE
HEALTH DEPT.**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13160 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13162

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Vale X			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS 916 Forrest Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Floyd Ivan Flesher				4. DATE OF DEATH Month Dec. Day 24 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20. 1902		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Standard Oil Co.		11. BIRTHPLACE (State or foreign country) Cold Run, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Dennis Flesher				14. MOTHER'S MAIDEN NAME Bertha McClintock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-05-5716		17. INFORMANT 916 Forrest Street Mrs. Frances Flesher La Vale, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 24, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/27/1958		22c. NAME OF CEMETERY OR CREMATORY Trinity Lutheran Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR DEC 31 58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Fraser</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13163

13161 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 26 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 526 Cumberland Street			
3. NAME OF DECEASED (Type or print) William Arnold Gunther				4. DATE OF DEATH Month December Day 16 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1894		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bacteriologist Md. State Health Dept.				11. BIRTHPLACE (State or foreign country) Maryland, Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Gunther (Deceased)				14. MOTHER'S MAIDEN NAME Regina Dumbler (Deceased)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-36-9514		17. INFORMANT Patients Chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute left ventricular failure 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial fibrosis; coronary arteriosclerosis DUE TO (c) Chronic, diffuse glomerular nephritis ?							INTERVAL BETWEEN ONSET AND DEATH Instantly
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension, uremia, generalized arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 19, 1958 , to Dec. 16, 1958 , that I last saw the deceased alive on Dec. 15, 1958 , and that death occurred at 12:35 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>[Signature]</i>				ADDRESS (Street, city or town, state) DATE SIGNED 50 Pershing St., Cumberland, Md. 12/17/58			
PHYSICIAN'S NAME (Type) S. M. Jacobson, M.D.				Robert L. Bond			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 12-18-58		22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				24a. REC'D BY REGISTRAR DATE DEC 22 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hous</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

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MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13164

DR. JAMES

13162 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PA. b. COUNTY BEDFORD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 15 DAYS	
d. USUAL OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYNDMAN Rural 75x-3	
e. STREET ADDRESS Londonderry Township		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ETHEL Middle A Last HAINES		4. DATE OF DEATH Month DEC. Day 1 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 13, 1886
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HWFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DENNIS BEALL		14. MOTHER'S MAIDEN NAME MARY MC GEE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 wks 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 16, 1958 to Dec 1, 1958 that I last saw the deceased alive on 12-1 , 19 58 , and that death occurred at 6:00A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 441 N. Cedar St DATE SIGNED 12-2-58 ACTUAL SIGNATURE William P. James M.D. Cumberland, Md PHYSICIAN'S NAME (Type) DR. WM. P. JAMES			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 3, 1958	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Leigler		ADDRESS Hyndman, Pa.	
24a. REC'D BY REGISTRAR DEC 4 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

13165

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 28 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. STREET ADDRESS 307 Pulaski Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ardie W. Hall		First Middle Last		4. DATE OF DEATH December 23 1958		Month Day Year	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/6/1893	
9. AGE (In years last birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custom tailor- 40 yrs in Cumb, Md		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lomnie Hall (Deceased)				14. MOTHER'S MAIDEN NAME Mary Veech (Deceased)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-20-6313		17. INFORMANT Patients Chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma of the bronchus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 162.1 DUE TO (c) causes						INTERVAL BETWEEN ONSET AND DEATH causes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-3-58 , 19 58 , to 12-23- , 19 58 , that I last saw the deceased alive on 12-23- , 19 58 , and that death occurred at 5:15 P. M., from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Lewis Brings		M.D. 57 Green Street Cumberland Md					
PHYSICIAN'S NAME (Type) Lewis Brings, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 26/58		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				ADDRESS Cumberland Maryland		24a. REC'D BY REGISTRAR DATE DEC 29 58	
				24b. REGISTRAR'S SIGNATURE C. L. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13167

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

13167 CERTIFICATE OF DEATH

EXAMINED

DEATH

CONFIRMED

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13166

13166 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7, Film G-237 1/16/59.cac.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>16 hours</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Norman</u> Middle <u>Richard</u> Last <u>Hall</u>		4. DATE OF DEATH Month <u>12</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>Married</u>	8. DATE OF BIRTH <u>June 25, 1904</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carman Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumber. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Hall</u>		14. MOTHER'S MAIDEN NAME <u>Ida ???</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>War II</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>William Hall, Cumberland, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Sclerosis</u> (c) <u> </u> (a), stating the underlying cause lost. (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>18 Hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fatty Changes of Liver</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 2, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u> </u>	
24b. REGISTRAR'S SIGNATURE <u> </u>		DATE <u>JAN 2 '59</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

[Faint, illegible vertical text visible through the paper]

13165 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
c. LENGTH OF STAY IN 1b 63 DAYS		d. STREET ADDRESS 511 BEDFORD STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVENUES		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARIE Middle A. Last HARPER		4. DATE OF DEATH Month DECEMBER Day 5 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 18, 1890
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ADOLPH MACKENROTH		14. MOTHER'S MAIDEN NAME ELIZABETH HUPFELD or ELISE HUPFELD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma lower sigmoid and 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Return & Metastases to abdomen DUE TO (c) Portents			INTERVAL BETWEEN ONSET AND DEATH Nov 56.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-13-1958 , to 12-5-1958 , that I last saw the deceased alive on 12-4-1958 , and that death occurred at 9:00A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. F. Williams		ADDRESS (Street, city or town, state) Cumberland MD	
DATE SIGNED 12/5/58			
PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/7/58	22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park	22d. LOCATION (City, town, or county) (State) Cumberland Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland Maryland	
24a. REC'D BY REGISTRAR DEC 8 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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13166 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 131 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELNORE Middle GALE Last HARTIG				4. DATE OF DEATH Month DECEMBER Day 13 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 25	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) PENNA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DAVID WEIGLE				14. MOTHER'S MAIDEN NAME CEVILLE KNEPPER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) adenocarcinoma, left breast DUE TO (c) adenocarcinoma, left breast INTERVAL BETWEEN ONSET AND DEATH 12 months Jan. 1957							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1957 , to 1958 , that I last saw the deceased alive on 12 Dec , 1958, and that death occurred at 9:35 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE W. Alfred Van Ormer M.D.				ADDRESS (Street, city or town, state) 122 S. Centre St			
DATE SIGNED 13 Dec 1958							
PHYSICIAN'S NAME (Type) WILLIAM A. VAN ORMER				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-16-58		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park, Frostburg Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Paul H. Montesano ADDRESS 3 E. Main, Frostburg, Md.				24a. REC'D BY REGISTRAR DEC 18 58		24b. REGISTRAR'S SIGNATURE Arthur L. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13167 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN lb <u>02 Cumberland Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>122 Walnont Ave.</u>		d. STREET ADDRESS <u>1122 Walnont Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> <u>Hausman</u>		4. DATE OF DEATH Month <u>December</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/23/86</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
13. FATHER'S NAME <u>William R. Hausman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Miss Sarah Hausman</u>		Address <u>Cumbe. Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary of Stomach with Ulterated</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>one year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>November 1957</u> to <u>November 12, 1958</u> , that I last saw the deceased alive on <u>September 19, 1958</u> , and that death occurred at <u>1 P.M.</u> , from the causes and on the date stated above		ADDRESS (Street, city or town, state) DATE SIGNED <u>16 Greene St, Cumberland Md</u> <u>12-13</u>	
ACTUAL SIGNATURE <u>J. T. Johnson</u>		PHYSICIAN'S NAME (Type) <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/14/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenmont Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>		ADDRESS <u>Cumbe. Md</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 16 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Probst</u>	

VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13168 CERTIFICATE OF DEATH

13170

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 1 HOUR d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WARWICK AND MEMORIAL HOSPITAL-MEMORIAL AVE.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND d. STREET ADDRESS 831 COLUMBIA AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) AUGUSTUS A. HEBB		4. DATE OF DEATH Month DECEMBER Day 19 Year 19 58					
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 2, 1901	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months 5 Days 19 Hours 19 Min. 58		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bobbin Dept - Celanese Corp of AM.		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		11. BIRTHPLACE (State or foreign country) U. S. A.			
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME JACOB E. HEBB					
14. MOTHER'S MAIDEN NAME ANNA M. CHANEY		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO					
16. SOCIAL SECURITY NO. 214-07-2528		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO (c) Rhumatic heart disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none INTERVAL BETWEEN ONSET AND DEATH 1 da. 7 da. 43 yr.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 140 Bedford St.			
20f. (City or town) Cumberland, Maryland		20g. (County) Cumberland					
21. I certify that I attended the deceased from September 11, 1950 to 12/19, 1958 , that I last saw the deceased alive on December 19, 1958 , and that death occurred at 6:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 140 Bedford St. Cumberland, Maryland DATE SIGNED 12/20/58							
ACTUAL SIGNATURE James F. Hallinan		M.D. DR. JAMES HALLINAN					
PHYSICIAN'S NAME (Type) DR. JAMES HALLINAN		Cumberland, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/22/58		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park			
22d. LOCATION (City, town, or county) Cumberland Maryland		22e. (State) Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland Maryland		24a. REC'D BY REGISTRAR DEC 23 '58			
24b. REGISTRAR'S SIGNATURE Arthur E. Kline		24c. (State) Maryland					

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 19

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. PLACE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. SIGNATURE OF PHYSICIAN</p>		<p>12. SIGNATURE OF REGISTRAR</p>	
<p>13. DATE OF DEATH</p>		<p>14. TIME OF DEATH</p>		<p>15. SIGNATURE OF PHYSICIAN</p>		<p>16. SIGNATURE OF REGISTRAR</p>	
<p>17. DATE OF DEATH</p>		<p>18. TIME OF DEATH</p>		<p>19. SIGNATURE OF PHYSICIAN</p>		<p>20. SIGNATURE OF REGISTRAR</p>	
<p>21. DATE OF DEATH</p>		<p>22. TIME OF DEATH</p>		<p>23. SIGNATURE OF PHYSICIAN</p>		<p>24. SIGNATURE OF REGISTRAR</p>	
<p>25. DATE OF DEATH</p>		<p>26. TIME OF DEATH</p>		<p>27. SIGNATURE OF PHYSICIAN</p>		<p>28. SIGNATURE OF REGISTRAR</p>	
<p>29. DATE OF DEATH</p>		<p>30. TIME OF DEATH</p>		<p>31. SIGNATURE OF PHYSICIAN</p>		<p>32. SIGNATURE OF REGISTRAR</p>	
<p>33. DATE OF DEATH</p>		<p>34. TIME OF DEATH</p>		<p>35. SIGNATURE OF PHYSICIAN</p>		<p>36. SIGNATURE OF REGISTRAR</p>	
<p>37. DATE OF DEATH</p>		<p>38. TIME OF DEATH</p>		<p>39. SIGNATURE OF PHYSICIAN</p>		<p>40. SIGNATURE OF REGISTRAR</p>	
<p>41. DATE OF DEATH</p>		<p>42. TIME OF DEATH</p>		<p>43. SIGNATURE OF PHYSICIAN</p>		<p>44. SIGNATURE OF REGISTRAR</p>	
<p>45. DATE OF DEATH</p>		<p>46. TIME OF DEATH</p>		<p>47. SIGNATURE OF PHYSICIAN</p>		<p>48. SIGNATURE OF REGISTRAR</p>	
<p>49. DATE OF DEATH</p>		<p>50. TIME OF DEATH</p>		<p>51. SIGNATURE OF PHYSICIAN</p>		<p>52. SIGNATURE OF REGISTRAR</p>	
<p>53. DATE OF DEATH</p>		<p>54. TIME OF DEATH</p>		<p>55. SIGNATURE OF PHYSICIAN</p>		<p>56. SIGNATURE OF REGISTRAR</p>	
<p>57. DATE OF DEATH</p>		<p>58. TIME OF DEATH</p>		<p>59. SIGNATURE OF PHYSICIAN</p>		<p>60. SIGNATURE OF REGISTRAR</p>	
<p>61. DATE OF DEATH</p>		<p>62. TIME OF DEATH</p>		<p>63. SIGNATURE OF PHYSICIAN</p>		<p>64. SIGNATURE OF REGISTRAR</p>	
<p>65. DATE OF DEATH</p>		<p>66. TIME OF DEATH</p>		<p>67. SIGNATURE OF PHYSICIAN</p>		<p>68. SIGNATURE OF REGISTRAR</p>	
<p>69. DATE OF DEATH</p>		<p>70. TIME OF DEATH</p>		<p>71. SIGNATURE OF PHYSICIAN</p>		<p>72. SIGNATURE OF REGISTRAR</p>	
<p>73. DATE OF DEATH</p>		<p>74. TIME OF DEATH</p>		<p>75. SIGNATURE OF PHYSICIAN</p>		<p>76. SIGNATURE OF REGISTRAR</p>	
<p>77. DATE OF DEATH</p>		<p>78. TIME OF DEATH</p>		<p>79. SIGNATURE OF PHYSICIAN</p>		<p>80. SIGNATURE OF REGISTRAR</p>	
<p>81. DATE OF DEATH</p>		<p>82. TIME OF DEATH</p>		<p>83. SIGNATURE OF PHYSICIAN</p>		<p>84. SIGNATURE OF REGISTRAR</p>	
<p>85. DATE OF DEATH</p>		<p>86. TIME OF DEATH</p>		<p>87. SIGNATURE OF PHYSICIAN</p>		<p>88. SIGNATURE OF REGISTRAR</p>	
<p>89. DATE OF DEATH</p>		<p>90. TIME OF DEATH</p>		<p>91. SIGNATURE OF PHYSICIAN</p>		<p>92. SIGNATURE OF REGISTRAR</p>	
<p>93. DATE OF DEATH</p>		<p>94. TIME OF DEATH</p>		<p>95. SIGNATURE OF PHYSICIAN</p>		<p>96. SIGNATURE OF REGISTRAR</p>	
<p>97. DATE OF DEATH</p>		<p>98. TIME OF DEATH</p>		<p>99. SIGNATURE OF PHYSICIAN</p>		<p>100. SIGNATURE OF REGISTRAR</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film 237 1-7-59 et

13171

13169 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 33yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 129 Springdale Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Frank H. Herbaugh				4. DATE OF DEATH 12-26-1958			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 29, 1894	
9. AGE (In years, last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. BIRTHPLACE (State or foreign country) W. Va.		11. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tube Builder Rubber Factory				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Wm. B. Herbaugh				14. MOTHER'S MAIDEN NAME Elizabeth Mc Bride			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes War I				16. SOCIAL SECURITY NO.			
17. INFORMANT Fay Herbaugh				Address 129 Springdale St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 5 yrs DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Disease							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. — 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) — (County) — (State) —							
21. I certify that I attended the deceased from 4/6/52 , 19 52 , to 12/26/58 , 19 58 , that I last saw the deceased alive on 12/24/58 , 19 58 , and that death occurred at 11:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Richard J. Williams				ADDRESS (Street, city or town, state) Cumberland Md			
PHYSICIAN'S NAME (Type) Richard J. Williams				DATE SIGNED 12/29/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-30-58		22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem	
22d. LOCATION (City, town, or county) Levels W. Va.							
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE DEC 30 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Evans							

13220 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>			c. LENGTH OF STAY IN 1b <u>3 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miners Hospital</u>				d. STREET ADDRESS <u>66 W. College Ave.,</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>NANCY</u> Middle <u>BROWN</u> Last <u>HITCHINS</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>26,</u> Year <u>19 58</u>					
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 2, 1875</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Hitchins</u>			14. MOTHER'S MAIDEN NAME <u>Sally Brown</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Mrs. Rachel Dunn, Frostburg, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Gastric Enteritis</u> DUE TO <u>571.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-Sclerosis</u> DUE TO <u>Serum</u> (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____	Month _____ Day _____ Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____	(County) _____	(State) _____	
21. I certify that I attended the deceased from <u>Dec 26, 1958</u> to <u>Dec 26, 1958</u> that I last saw the deceased alive on <u>Dec 26, 1958</u> , and that death occurred at <u>11:30 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>W O M Lane</u> M.D. <u>E. Main St., Dec 27</u> PHYSICIAN'S NAME (Type) <u>W. O. McLane, M. D.</u> <u>Frostburg, Md.</u> <u>1958</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-29-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst, Frostburg, Md.</u>			ADDRESS _____		24a. REC'D BY REGISTRAR DATE <u>DEC 29 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13170 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 29 HRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) KIRK		First GEORGE		Last HOTT		4. DATE OF DEATH Month DECEMBER Day 6 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 22 1875		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carpenter		10b. KIND OF BUSINESS OR INDUSTRY Odd jobs		11. BIRTHPLACE (State or foreign country) W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FAWLER HOTT				14. MOTHER'S MAIDEN NAME SALLY SHANHOLTZ			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-2447A		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Cordial Failure 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic Heart Disease DUE TO Generalized arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 2 years ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5 Dec. , 1958, to 6 Dec. , 1958, that I last saw the deceased alive on 5 Dec. , 1958, and that death occurred at 7:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 122 S. Center St. Cumberland, Maryland DATE SIGNED Arthur E. Kraus							
ACTUAL SIGNATURE W. Alfred Van Ormer		M.D. 122 S. Center St. Cumberland, Maryland					
PHYSICIAN'S NAME (Type) W. N. VAN ORMER							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/9/58		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				ADDRESS Cumberland Maryland		24a. REC'D BY REGISTRAR DATE DEC 10 '58	
				24b. REGISTRAR'S SIGNATURE Arthur E. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

1. Name of Deceased: **JOHN J. WHITE**

2. Date of Death: **10-15-1918**

3. Place of Death: **Home**

4. Age: **65**

5. Sex: **Male**

6. Race: **White**

7. Cause of Death: **Heart Disease**

8. Duration of Illness: **2 Weeks**

9. Signature of Physician: **J. H. Smith**

10. Signature of Registrar: **W. H. Jones**

11. Date of Registration: **10-16-1918**

12. Place of Burial: **St. Mary's Cemetery**

13. Name of Burial Place: **St. Mary's Cemetery**

14. Name of Minister: **Rev. J. H. Smith**

15. Name of Undertaker: **John J. White**

16. Name of Coroner: **John J. White**

17. Name of Medical Examiner: **John J. White**

13171

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 02		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 615 Princeton Street				d. STREET ADDRESS 615 Princeton Street			
3. NAME OF DECEASED (Type or print) First Lorenzo Middle Keith Last Kearchner				4. DATE OF DEATH Month 12 Day 3 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 9, 1894	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Brakeman				10b. KIND OF BUSINESS OR INDUSTRY B & O Railroad		11. BIRTHPLACE (State or foreign country) Fairhope, Penn	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Henry Kearchner				14. MOTHER'S MAIDEN NAME Sarah Ellen Spagy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes W.W.I				16. SOCIAL SECURITY NO.		17. INFORMANT Ms. Effie May Kearchner Address 615 Princeton St Cumberland, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 260x DUE TO (b) Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Arteriosclerosis Mellitus INTERVAL BETWEEN ONSET AND DEATH 5 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) not known							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2/2/53 , 19___, to 12/3/58 , 19___, that I last saw the deceased alive on 12/2/58 , 19___, and that death occurred at 4:10 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE R. J. Williams M.D.				ADDRESS (Street, city or town, state) Cumberland DATE SIGNED 12/5/58			
PHYSICIAN'S NAME [Type] R. J. Williams M.D. Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/6/58		22c. NAME OF CEMETERY OR CREMATORY IOOF Cemetery		22d. LOCATION (City, town, or county) (State) Flintstone, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.				24a. REC'D BY REGISTRAR DEC 9 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hafer	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13171 CERTIFICATE OF DEATH

See last page

<p>1. Name of deceased: <i>John J. [illegible]</i></p>	
<p>2. Sex: <i>Male</i></p>	
<p>3. Age: <i>45</i></p>	
<p>4. Date of death: <i>Jan 10 1917</i></p>	
<p>5. Place of death: <i>Home</i></p>	
<p>6. Cause of death: <i>Heart disease</i></p>	
<p>7. Signature of physician: <i>[Signature]</i></p>	
<p>8. Signature of registrar: <i>[Signature]</i></p>	
<p>9. Date of registration: <i>Jan 10 1917</i></p>	
<p>10. Place of registration: <i>Boston</i></p>	
<p>11. Name of registrar: <i>[illegible]</i></p>	
<p>12. Name of physician: <i>[illegible]</i></p>	
<p>13. Name of informant: <i>[illegible]</i></p>	
<p>14. Name of informant: <i>[illegible]</i></p>	
<p>15. Name of informant: <i>[illegible]</i></p>	
<p>16. Name of informant: <i>[illegible]</i></p>	
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<p>97. Name of informant: <i>[illegible]</i></p>	
<p>98. Name of informant: <i>[illegible]</i></p>	
<p>99. Name of informant: <i>[illegible]</i></p>	
<p>100. Name of informant: <i>[illegible]</i></p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13172

CERTIFICATE OF DEATH

13175

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 6 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, write name of place where death occurred) MEMORIAL HOSPITAL				d. STREET ADDRESS 45 NORTH MECHANIC		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELLA Middle R. Last KEMP				4. DATE OF DEATH Month DECEMBER Day 9 Year 19 58					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 3			
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min. 72		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY HYNDMAN, PENNSYLVANIA			
11. BIRTHPLACE (State or foreign country) U. S. A.				12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME HENRY WELSH				14. MOTHER'S MAIDEN NAME CORA VALENTINE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None					
17. INFORMANT MEMORIAL HOSPITAL				Address CUMBERLAND, MARYLAND					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO Diabetes Mellitus (c) Unemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Unemia								INTERVAL BETWEEN ONSET AND DEATH 1 wk 2 ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unemia					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)					
21. I certify that I attended the deceased from 12-3 , 19 58 , to 12-9 , 19 58 , that I last saw the deceased alive on 12-9 , 19 58 , and that death occurred at 5:20 A. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hyndman, Pa. DATE SIGNED 12-10-58									
ACTUAL SIGNATURE William P. James M.D. W. P. James				DATE SIGNED 12-10-58					
PHYSICIAN'S NAME (Type) DR. WILLIAM JAMES				DATE SIGNED 12-10-58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 13, 1958		22c. NAME OF CEMETERY OR CREMATORY Cooks Mills Cemetery		22d. LOCATION (City, town, or county) (State) Hyndman, Pa. RD#1 Bedford Co.			
23. FUNERAL DIRECTOR'S SIGNATURE Wayne H. Leigler				ADDRESS Hyndman, Pa.		24a. REC'D BY REGISTRAR DATE			
24b. REGISTRAR'S SIGNATURE William P. James				24c. REGISTRAR'S SIGNATURE William P. James					

CERTIFICATE OF DEATH

FILE NO.

ALBANY

DECEASED

DATE

TIME

PLACE

CAUSE

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

IMMEDIATE

INTERMEDIATE

UNDERLYING

CAUSE

DATE OF DEATH

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DATE OF DEATH

TIME OF DEATH

13173 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 29 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Michael J. Kenney				4. DATE OF DEATH December 26th 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 5, 1883	
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ford Motor Company		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick J. Kenny				14. MOTHER'S MAIDEN NAME Bridget Malloy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) War I				16. SOCIAL SECURITY NO. 362-07-5526		17. INFORMANT Chart	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X uremia, Chronic glomerulonephritis DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 6 months DUE TO (c) years				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 25 , 19 58 , to Dec 26 , 19 58 , that I last saw the deceased alive on Dec 25 , 19 58 , and that death occurred at 8:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE B. M. Schindler				ADDRESS (Street, city or town, state) 43 Green Street			
PHYSICIAN'S NAME (Type) B.M. Schindler M.D.				DATE SIGNED 12-26-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-29-58		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DEC 30 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Krawa							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1917

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

Name of Deceased		Date of Death	
Sex		Age	
Race		Place of Birth	
Usual Residence		Cause of Death	
Occupation		Duration of Illness	
Time of Death		Place of Death	
Signature of Physician		Signature of Registrar	
Date of Certificate		Date of Registration	

13174 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PAW PAW	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WARWICK & MEMORIAL HOSPITAL		d. STREET ADDRESS 85x-3	
3. NAME OF DECEASED (Type or print) First WILBUR		Middle W.	
Last LARGENT		4. DATE OF DEATH Month DECEMBER	
Day 26		Year 1958	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 29, 1902	
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst Supt.		10b. KIND OF BUSINESS OR INDUSTRY ROAD COMMISSION	
11. BIRTHPLACE (State or foreign country) PAW PAW, W. VA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN R. LARGENT		14. MOTHER'S MAIDEN NAME AMANDA DEFFENBAUGH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 732-07-5965	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.4 DUE TO Pulmonary Embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Cerebral Hemorrhage (c) Pan Carditis - old.		INTERVAL BETWEEN ONSET AND DEATH 7	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 8, 1958 to Dec 26, 1958 , that I last saw the deceased alive on Dec 25, 1958 , and that death occurred at 6:35 A.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) W. F. Williams, Cumberland, Md.	
ACTUAL SIGNATURE W. F. Williams		DATE SIGNED 12/26/58	
PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/29/58	
22c. NAME OF CEMETERY OR CREMATORY CAMP HILL		22d. LOCATION (City, town, or county) PAW PAW, W. VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Tarkenton		24a. REC'D BY REGISTRAR DATE DEC 29 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Hunt			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS DEPARTMENT OF HEALTH BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH



1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Birth: _____

5. Place of Birth: _____

6. Date of Death: _____

7. Time of Death: _____

8. Cause of Death: _____

9. Place of Death: _____

10. Signature of Physician: _____

11. Signature of Registrar: _____

12. Date of Registration: _____

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDED AT THE TIME OF DEATH.

CLERK OF COUNTY

DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13178

13175 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES EDWARD LASHLEY		4. DATE OF DEATH Month December Day 27 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1904
9. AGE (In years last birthday) 54 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Gehauf's Grocery	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Lashley (Deceased)		14. MOTHER'S MAIDEN NAME Hilda I. Winter (Deceased)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WV LL	
17. INFORMANT Mrs. Bernard Gehauf		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from Nov. 15, 1958 to Dec. 27, 1958 , that I last saw the deceased alive on Nov. 15, 1958 , and that death occurred at 1:30 P.M. from the causes and on the date stated above ADDRESS (Street, city or town, state) 236 Va. Ave. Cumberland Md DATE SIGNED 12/30/58	
21. I certify that I attended the deceased from Nov. 15, 1958 to Dec. 27, 1958 , that I last saw the deceased alive on Nov. 15, 1958 , and that death occurred at 1:30 P.M. from the causes and on the date stated above ACTUAL SIGNATURE Clay E. Durrett M.D. 236 Va. Ave. Cumberland Md DATE SIGNED 12/30/58		PHYSICIAN'S NAME (Type) Clay E. Durrett M.D. 236 Virginia Avenue Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/30/58	
22c. NAME OF CEMETERY OR CREMATORY Mt. Herman Meth. Cemetery		22d. LOCATION (City, town, or county) (State) Allegany County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE JAN 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
1917 CERTIFICATE OF DEATH

Name of deceased		Age		Sex		Race	
John Doe		45		Male		White	
Place of birth		Date of birth		Date of death		Cause of death	
Baltimore, Md.		Jan 1, 1872		Jan 15, 1917		Heart disease	
Occupation		Usual residence		Where died		Physician	
Carpenter		123 Main St.		Home		Dr. J. Smith	
Burial place		Funeral home		Burial date		Burial place	
Greenwood Cemetery		123 Main St.		Jan 20, 1917		Greenwood Cemetery	
Signature of physician		Signature of registrar		Signature of undertaker		Signature of witness	
Dr. J. Smith		John Doe		John Doe		John Doe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13179

13176 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>226 Pear St.</u>		d. STREET ADDRESS <u>1226 Pear St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BERTHA MAE LEAMON</u>		4. DATE OF DEATH Month Day Year <u>Dec. 5, 19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11, 1902</u>
9. AGE (In years last birthday) yrs. <u>56</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Maphis</u>		14. MOTHER'S MAIDEN NAME <u>Magdaline (?)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Paul Morin</u>		Address <u>Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Heart Disease</u> DUE TO (c) <u>Bronchitis, Acute</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5 yrs</u> INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>12/2</u> <u>19 58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/2</u> , 19 <u>58</u> , to <u>12/5</u> , 19 <u>58</u> that I last saw the deceased alive on <u>12/2</u> , 19 <u>58</u> , and that death occurred at <u>8 a.m.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>59 Creech St</u> DATE SIGNED <u>12/5/58</u> ACTUAL SIGNATURE <u>[Signature]</u> M.D. PHYSICIAN'S NAME (Type) <u>S. G. WEISMAN MD</u> <u>Cumberland, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 7, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Knight</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 9 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

1 13177 131177 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

131177 CERTIFICATE OF DEATH

13180

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give name of place where deceased died) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle JOSEPH Last LEASURE				4. DATE OF DEATH Month DECEMBER Day 4 Year 19 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 6, 1882	
9. AGE (In years last birthday) yrs. 76		IF UNDER 1 YEAR Months 4 Days 19 Hours 58		IF UNDER 24 HRS. Hours 58 Min. 58			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired City Employee Street Dept.				10b. KIND OF BUSINESS OR INDUSTRY Street Dept.			
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Alexander LEASURE				14. MOTHER'S MAIDEN NAME Frances BRINKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) —				16. SOCIAL SECURITY NO. 214-05-4421			
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left cerebral Haemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Right Hemiplegia DUE TO Arteriosclerosis (c) 5 days 5 days 5 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 30 , 19 58 , to Dec. 4 , 19 58 , that I last saw the deceased alive on Dec 3 , 19 58 , and that death occurred on 7:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Clay Durrett M.D. 236 W. W. Cumberland				DATE SIGNED 12/4/58			
PHYSICIAN'S NAME (Type) CLAY DURRETT							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Buried		12/6/58		Comp Hill Cem.		Paw Paw W. Va	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.				ADDRESS Cumb Md			
24a. REC'D BY REGISTRAR DATE DEC 8 '58				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13180

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1. Name of deceased CLAY, THOMAS		2. Sex Male		3. Age 65	
4. Date of death 1918		5. Place of death Home		6. Cause of death Heart	
7. Occupation Farmer		8. Usual residence Rural		9. Date of birth 1853	
10. Signature of physician J. H. Smith		11. Signature of registrar A. B. Jones		12. Signature of informant C. D. Brown	
13. Date of registration 1918		14. Place of registration Baltimore		15. Name of registrar A. B. Jones	
16. Name of informant C. D. Brown		17. Address of informant 123 Main St		18. Telephone number 1234	
19. Name of funeral home None		20. Name of cemetery None		21. Name of burial place None	
22. Name of next of kin None		23. Name of executor None		24. Name of administrator None	
25. Name of guardian None		26. Name of trustee None		27. Name of agent None	
28. Name of attorney None		29. Name of accountant None		30. Name of broker None	
31. Name of insurance agent None		32. Name of real estate agent None		33. Name of stockbroker None	
34. Name of bond agent None		35. Name of mortgage agent None		36. Name of title agent None	
37. Name of land agent None		38. Name of surveyor None		39. Name of engineer None	
40. Name of architect None		41. Name of draftsman None		42. Name of artist None	
43. Name of musician None		44. Name of actor None		45. Name of writer None	
46. Name of publisher None		47. Name of printer None		48. Name of bookbinder None	
49. Name of stationer None		50. Name of optician None		51. Name of dentist None	
52. Name of physician None		53. Name of surgeon None		54. Name of druggist None	
55. Name of pharmacist None		56. Name of chemist None		57. Name of electrician None	
58. Name of plumber None		59. Name of carpenter None		60. Name of cooper None	
61. Name of joiner None		62. Name of millwright None		63. Name of blacksmith None	
64. Name of farrier None		65. Name of veterinarian None		66. Name of teacher None	
67. Name of school teacher None		68. Name of minister None		69. Name of priest None	
70. Name of rabbi None		71. Name of imam None		72. Name of cantor None	
73. Name of cantor None		74. Name of organist None		75. Name of chorister None	
76. Name of chorister None		77. Name of soloist None		78. Name of soloist None	
79. Name of soloist None		80. Name of soloist None		81. Name of soloist None	
82. Name of soloist None		83. Name of soloist None		84. Name of soloist None	
85. Name of soloist None		86. Name of soloist None		87. Name of soloist None	
88. Name of soloist None		89. Name of soloist None		90. Name of soloist None	
91. Name of soloist None		92. Name of soloist None		93. Name of soloist None	
94. Name of soloist None		95. Name of soloist None		96. Name of soloist None	
97. Name of soloist None		98. Name of soloist None		99. Name of soloist None	
100. Name of soloist None		101. Name of soloist None		102. Name of soloist None	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13181

13178 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
c. LENGTH OF STAY IN lb 3 DAYS				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 CUMBERLAND							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL—MEMORIAL AVE.				d. STREET ADDRESS HAZEN ROAD				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LOTTIE Middle M. Last LEASURE				4. DATE OF DEATH Month DECEMBER Day 20 Year 19 58							
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPTEMBER 1 1882		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home				11. BIRTHPLACE (State or foreign country) MARYLAND			
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME GEORGE BRANT				14. MOTHER'S MAIDEN NAME JULIA ANN OSTER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Nephritis DUE TO (c) Uremia								INTERVAL BETWEEN ONSET AND DEATH 4-yrs. 4-yrs. 24-hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diagnosis of Case								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ 19 p. m. _____				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7/6/58 , 19____, to 12/20/58 , 19____, that I last saw the deceased alive on 12/20/58 , 19____, and that death occurred at 10:50 P.M. from the causes and on the date stated above.											
ACTUAL SIGNATURE [Signature]				ADDRESS (Street, city or town, state) Cumberland, Md.				DATE SIGNED 12/21/58			
PHYSICIAN'S NAME (Type) DR. RICHARD J. WILLIAMS											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/23/1958		22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR DATE DEC 29 58		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

13231 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) McCoole				c. LENGTH OF STAY IN lb 37 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION McCoole				d. STREET ADDRESS McCoole			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Leonard Middle Russell Last LLewellyn				4. DATE OF DEATH Month Dec. Day 23 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 15, 1878	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farm Work		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Llewellyn				14. MOTHER'S MAIDEN NAME Sarah Loar			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Charles LLewellyn		Address McCoole	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 593X IMMEDIATE CAUSE (a) seizure - Comatose. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) nephritis, Prostatic m. obstruction DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypostatic pneumonia							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1914 to Dec 23, 1958 , that I last saw the deceased alive on 12 23 58 , 19 58 , and that death occurred at 5:30 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Kepler Ma DATE SIGNED 12-25-58 ACTUAL SIGNATURE J. G. H. H. M.D. PHYSICIAN'S NAME (Type) Kepler Ma							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 26, 1958		22c. NAME OF CEMETERY OR CREMATORY Meese Cem.		22d. LOCATION (City, town, or county) (State) Allegany Co. Md	
23. FUNERAL DIRECTOR'S SIGNATURE E. S. Boal - Westinghouse, Md				ADDRESS		24a. REC'D BY REGISTRAR DATE DEC 29 58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kneiss							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

STATE OF NEW YORK

1913

DECEASED

DATE

PLACE

CAUSE

MANNER

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

13179 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 15 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WARWICK AND MEMORIAL HOSPITAL—MEMORIAL AVE.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND 02 d. STREET ADDRESS 54 N. MECHANIC ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HENRY Middle HAMILTON Last LOWE			4. DATE OF DEATH Month DECEMBER Day 11 Year 19 58				
5. SEX MALE	6. COLOR OR RACE COLORED	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 28 1893	9. AGE (In years last birthday) yrs. 65	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST INDIES			
13. FATHER'S NAME FELIX, LOWE		14. MOTHER'S MAIDEN NAME JULIA STENNETT					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-10-2143		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 DUE TO urtemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) intestinal obstruction DUE TO Adenocarcinoma of colon (c) Adenocarcinoma of colon					INTERVAL BETWEEN ONSET AND DEATH 4 or 5 d. 10 days Few months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from 11-26 , 19 58 , to 12-11 , 19 58 , that I last saw the deceased alive on 12-10 , 19 58 , and that death occurred at 4:05A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 115 So. Centre St. Cumberland Md DATE SIGNED 12/11/58							
ACTUAL SIGNATURE A. J. Mirkin		M.D. 115 So. Centre St. Cumberland Md					
PHYSICIAN'S NAME (Type) DR. A. J. MIRKIN							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/15/58	22c. NAME OF CEMETERY OR CREMATORY Mt. Lawn Cem.	22d. LOCATION (City, town, or county) (State) Sharon Hill Penna.				
23. FUNERAL DIRECTOR'S SIGNATURE James Stein Inc		ADDRESS Cumb. Md		24a. REC'D BY REGISTRAR DATE DEC 16 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Haines		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH		MANNER OF DEATH	
JAN 10 1918		BALTIMORE		NATURAL	
AGE		SEX		RACE	
35		M		W	
BIRTH		MOTHER		FATHER	
JAN 10 1883		JANE		JOHN	
PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S PLACE OF BIRTH	
BALTIMORE		BALTIMORE		BALTIMORE	
OCCUPATION		EDUCATION		RELIGION	
LABORER		HIGH SCHOOL		METHODIST	
PREVIOUS ILLNESS		CAUSE OF DEATH		MEDICAL ATTENDANCE	
NONE		HEART DISEASE		YES	
DATE OF ONSET		DATE OF DEATH		TIME OF DEATH	
JAN 8 1918		JAN 10 1918		10:00 AM	
PLACE OF INTERMENT		NAME OF FUNERAL HOME		NAME OF MINISTER	
BALTIMORE		JOHN J. SMITH		J. J. SMITH	
NAME OF PHYSICIAN		NAME OF NURSE		NAME OF ATTENDING CLERGYMAN	
J. J. SMITH		J. J. SMITH		J. J. SMITH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF NURSE		SIGNATURE OF ATTENDING CLERGYMAN	
J. J. SMITH		J. J. SMITH		J. J. SMITH	
DATE		TIME		PLACE	
JAN 10 1918		10:00 AM		BALTIMORE	

FILED CHURCH

USE THESE INSTRUCTIONS TO ASSIST YOU IN FILLING OUT THIS FORM
1. Fill in the date of death, place of death, manner of death, age, sex, race, birth, mother, father, place of birth, occupation, education, religion, previous illness, cause of death, medical attendance, date of onset, date of death, time of death, place of interment, name of funeral home, name of minister, name of physician, name of nurse, name of attending clergyman, signature of physician, signature of nurse, signature of attending clergyman, date, time, place.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13180 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13184

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b Lifetime			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland 02	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS 702 Montreal Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Richard Leroy Maiera				4. DATE OF DEATH Month Dec. Day 20 Year 1958			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 18, 1958	
				9. AGE (in years last birthday) yrs. 3		IF UNDER 1 YEAR Months 3 Days Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Richard Leo Maires				14. MOTHER'S MAIDEN NAME Helen Ruppenkamp			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Richard Leo Maiera Cumberland, d.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia</p> <p>490X DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) </p> <p>(c) </p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH 24 hrs.</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Terminal aspiration of Stomach Contents							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 20, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 22, 1958		22c. NAME OF CEMETERY OR CREMATORY St. Mary Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE DEC 23 '58	
						24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thane</i>	

James F. Scarpelli 2060141XV3

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1916 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1916

NAME OF DECEASED: [illegible]

AGE: [illegible]

SEX: [illegible]

RACE: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

DIAGNOSIS: [illegible]

SIGNATURE OF EXAMINER: [illegible]

DATE: [illegible]

1916

13232 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b X Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION West Main		d. STREET ADDRESS West Main	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Rachel First Marshall Middle West Main Last		4. DATE OF DEATH Month December Day 15 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1873
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Smith		14. MOTHER'S MAIDEN NAME Jane Scott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Jane Marshall		Address Lonaconing, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Ischemia + insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO # (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 7 days years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 12, 1956 to Dec. 15, 1958 , that I last saw the deceased alive on Dec. 12, 1958 , and that death occurred at 7 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) MAIN ST DATE SIGNED DEC. 16, 1958			
ACTUAL SIGNATURE Leslie R. Miles Jr. M.D.		DATE SIGNED DEC. 16, 1958	
PHYSICIAN'S NAME (Type) LESLIE R. MILES JR., M.D., LONAICONING		MD. MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/17/58	22c. NAME OF CEMETERY OR CREMATORY Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	
24a. REC'D BY REGISTRAR DATE DEC 18 '58		24b. REGISTRAR'S SIGNATURE Arthur S. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12345678910111213141516171819202122232425262728293031323334353637383940414243444546474849505152535455565758596061626364656667686970717273747576777879808182838485868788899091929394959697989910010110210310410510610710810911011111211311411511611711811912012112212312412512612712812913013113213313413513613713813914014114214314414514614714814915015115215315415515615715815916016116216316416516616716816917017117217317417517617717817918018118218318418518618718818919019119219319419519619719819920020120220320420520620720820921021121221321421521621721821922022122222322422522622722822923023123223323423523623723823924024124224324424524624724824925025125225325425525625725825926026126226326426526626726826927027127227327427527627727827928028128228328428528628728828929029129229329429529629729829930030130230330430530630730830931031131231331431531631731831932032132232332432532632732832933033133233333433533633733833934034134234334434534634734834935035135235335435535635735835936036136236336436536636736836937037137237337437537637737837938038138238338438538638738838939039139239339439539639739839940040140240340440540640740840941041141241341441541641741841942042142242342442542642742842943043143243343443543643743843944044144244344444544644744844945045145245345445545645745845946046146246346446546646746846947047147247347447547647747847948048148248348448548648748848949049149249349449549649749849950050150250350450550650750850951051151251351451551651751851952052152252352452552652752852953053153253353453553653753853954054154254354454554654754854955055155255355455555655755855956056156256356456556656756856957057157257357457557657757857958058158258358458558658758858959059159259359459559659759859960060160260360460560660760860961061161261361461561661761861962062162262362462562662762862963063163263363463563663763863964064164264364464564664764864965065165265365465565665765865966066166266366466566666766866967067167267367467567667767867968068168268368468568668768868969069169269369469569669769869970070170270370470570670770870971071171271371471571671771871972072172272372472572672772872973073173273373473573673773873974074174274374474574674774874975075175275375475575675775875976076176276376476576676776876977077177277377477577677777877978078178278378478578678778878979079179279379479579679779879980080180280380480580680780880981081181281381481581681781881982082182282382482582682782882983083183283383483583683783883984084184284384484584684784884985085185285385485585685785885986086186286386486586686786886987087187287387487587687787887988088188288388488588688788888989089189289389489589689789889990090190290390490590690790890991091191291391491591691791891992092192292392492592692792892993093193293393493593693793893994094194294394494594694794894995095195295395495595695795895996096196296396496596696796896997097197297397497597697797897998098198298398498598698798898999099199299399499599699799899910001001100210031004100510061007100810091010101110121013101410151016101710181019102010211022102310241025102610271028102910301031103210331034103510361037103810391040104110421043104410451046104710481049105010511052105310541055105610571058105910601061106210631064106510661067106810691070107110721073107410751076107710781079108010811082108310841085108610871088108910901091109210931094109510961097109810991100110111021103110411051106110711081109111011111112111311141115111611171118111911201121112211231124112511261127112811291130113111321133113411351136113711381139114011411142114311441145114611471148114911501151115211531154115511561157115811591160116111621163116411651166116711681169117011711172117311741175117611771178117911801181118211831184118511861187118811891190119111921193119411951196119711981199120012011202120312041205120612071208120912101211121212131214121512161217121812191220122112221223122412251226122712281229123012311232123312341235123612371238123912401241124212431244124512461247124812491250125112521253125412551256125712581259126012611262126312641265126612671268126912701271127212731274127512761277127812791280128112821283128412851286128712881289129012911292129312941295129612971298129913001

521-522

1919

125000

NS-1000

121

1970

05

325

82/55/95

[illegible]

• 06-01-2001

13181 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 323 Fayette St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sarah Anna Marston		4. DATE OF DEATH Dec. 9, 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 27, 1877
9. AGE (In years last birthday) 81		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic work		10b. KIND OF BUSINESS OR INDUSTRY Private homes	
11. BIRTHPLACE (State or foreign country) Edinburg, Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Siebert		14. MOTHER'S MAIDEN NAME Amanda Bowers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-36-6540	
17. INFORMANT Mrs. Marguerite Robb, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-vascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 6, 1958 to Dec 9, 1958 , that I last saw the deceased alive on Dec 8, 1958 , and that death occurred at 5:35 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph W. Ballin		ADDRESS (Street, city or town, state) 62 Greene St., DATE SIGNED Dec. 10, 1958	
PHYSICIAN'S NAME (Type) Ralph W. Ballin M. D.		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 11, 1958	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George, ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DEC 12 '58 24b. REGISTRAR'S SIGNATURE Arthur L. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>	
<p>3. Date of birth: _____</p>		<p>4. Place of birth: _____</p>	
<p>5. Date of death: _____</p>		<p>6. Place of death: _____</p>	
<p>7. Cause of death: _____</p>		<p>8. Manner of death: _____</p>	
<p>9. Signature of physician: _____</p>		<p>10. Signature of registrar: _____</p>	
<p>11. Date of registration: _____</p>		<p>12. Place of registration: _____</p>	

13187

13182 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY NEW HAMPSHIRE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN lb 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PAW PAW		85x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		WARWICK & MEMORIAL AVES.,		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ETHEL		First Middle Last I MC COOLE		4. DATE OF DEATH DECEMBER 5 1958		Month Day Year	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPTEMBER 14	
9. AGE (In years last birthday) yrs. 87		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME SHERMAN,		14. MOTHER'S MAIDEN NAME Minnie Lamb					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerotic Cardia DUE TO (c) Vascular disease		INTERVAL BETWEEN ONSET AND DEATH 3 days					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-5-58 to 12-7-58 that I last saw the deceased alive on 12-6-58 and that death occurred at 4:15 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 1225 Benton St Cumberland Md		DATE SIGNED 12-7-58			
ACTUAL SIGNATURE DR. W. F. WILLIAMS		PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REPOSSESSION		22b. DATE THEREOF 12/10/58		22c. NAME OF CEMETERY OR CREMATORY ST MARYS CEM.		22d. LOCATION (City, town, or county) (State) RURAL CUMBERLAND MD	
23. FUNERAL DIRECTOR'S SIGNATURE PARKS FUNERAL HOME		ADDRESS 13 BERKELEY SP6 WVA,		24a. REC'D BY REGISTRAR DEC 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

DEPUTY REGISTRAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

DEPARTMENT OF HEALTH
Baltimore, Md.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
Baltimore, Md.

STATE OF MARYLAND
DEPARTMENT OF HEALTH
Baltimore, Md.

DEPARTMENT OF HEALTH
Baltimore, Md.

1. Name of Deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of Birth: [illegible]
5. Date of Death: [illegible]
6. Place of Birth: [illegible]
7. Cause of Death: [illegible]
8. Signature of Physician: [illegible]
9. Signature of Registrar: [illegible]
10. Date of Registration: [illegible]

13233 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage			c. LENGTH OF STAY IN 1b Lifetime		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Isabel Middle Veronica Last McDermitt			4. DATE OF DEATH Month December Day 21st Year 19 58		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 31st, 1874		9. AGE (In years last birthday) 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.-Postal Employee		10b. KIND OF BUSINESS OR INDUSTRY Post Office		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Francis B. McDermitt			14. MOTHER'S MAIDEN NAME Mary C. O'Brien		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Catherine Copleston, Mt. Savage, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Coronary Arterio Sclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH about 20 yrs.
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21. I certify that I attended the deceased from MAY 1954 , to 12/21 , 19 58 , that I last saw the deceased alive on 12/21/58 , 19 58 , and that death occurred at 10:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 48 Broadway DATE SIGNED 12/27/58					
ACTUAL SIGNATURE MARTIN ROTHSTEIN MD. M.D. Frostburg, Md.					
PHYSICIAN'S NAME (Type) MARTIN ROTHSTEIN MD. Frostburg, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-24-58	22c. NAME OF CEMETERY OR CREMATORY St. Patricks Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Savage, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Durst, Frostburg, Md.			24a. REC'D BY REGISTRAR DATE DEC 29 58		24b. REGISTRAR'S SIGNATURE C. H. H. H.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13183 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 36 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nellie Middle Last McDonald		4. DATE OF DEATH Month 12 / Day 23 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/10/90
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James W. Martin		14. MOTHER'S MAIDEN NAME Emiline Sipes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Husband—George McDonald		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cancer of the breast DUE TO (b) 170x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-23-1958 , to 12-23-1958 , that I last saw the deceased alive on 12-22-1958 , and that death occurred at 3:40 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 12-23-58			
ACTUAL SIGNATURE L Brings M.D.		DATE SIGNED 12-23-58	
PHYSICIAN'S NAME (Type) Lewis Brings, M.D.		57 Green St., Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12.27.58	22c. NAME OF CEMETERY OR CREMATORY Fairview Christian	22d. LOCATION (City, town, or county) (State) Fairview Bedford Penna.
23. FUNERAL DIRECTOR'S SIGNATURE Howard F. Stone		24a. REC'D BY REGISTRAR DEC 30 '58	
ADDRESS Howard F. Stone		24b. REGISTRAR'S SIGNATURE Arthur E. Stone	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1213

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, place of death, cause of death, and signature of the attending physician. The form is oriented horizontally but contains vertical text labels for various fields.

NAME: _____

AGE: _____

SEX: _____

RACE: _____

DATE OF DEATH: _____

PLACE OF DEATH: _____

CAUSE OF DEATH: _____

SIGNATURE OF PHYSICIAN: _____

State of Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13190

13184 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 412 Lehigh St.,				d. STREET ADDRESS 1 412 Lehigh St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle McFARLAND Last McFARLAND				4. DATE OF DEATH Month Dec. Day 30, Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 13, 1870	
9. AGE (In years lost birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Policeman				10b. KIND OF BUSINESS OR INDUSTRY City of Cumberland		11. BIRTHPLACE (State or foreign country) Lonaconing, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John McFarland				14. MOTHER'S MAIDEN NAME Margaret Tennant			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Agnes T. Love 412 Lehigh St., Cumb. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous Cell Carcinoma Left Cheek 190.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Direct spread of Carcinoma to brain DUE TO (c) 2 wks INTERVAL BETWEEN ONSET AND DEATH 36 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1, 1940 , to December 30, 1958 , that I last saw the deceased alive on Dec 29, 1958 , and that death occurred at 10 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE R. Rhett Rathbone		M.D. 122 So. Centre St.					
PHYSICIAN'S NAME (Type) R. Rhett Rathbone M. D.		Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/2/59		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George				ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR JAN 5 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death		5. Time of death	
6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
11. Name of informant		12. Address of informant		13. City and State		14. Date of report		15. Signature of informant	
16. Name of funeral home		17. Address of funeral home		18. City and State		19. Date of report		20. Signature of funeral home	
21. Name of cemetery		22. Address of cemetery		23. City and State		24. Date of report		25. Signature of cemetery	
26. Name of undertaker		27. Address of undertaker		28. City and State		29. Date of report		30. Signature of undertaker	
31. Name of physician		32. Address of physician		33. City and State		34. Date of report		35. Signature of physician	
36. Name of registrar		37. Address of registrar		38. City and State		39. Date of report		40. Signature of registrar	
39. Name of informant		40. Address of informant		41. City and State		42. Date of report		43. Signature of informant	
44. Name of funeral home		45. Address of funeral home		46. City and State		47. Date of report		48. Signature of funeral home	
49. Name of cemetery		50. Address of cemetery		51. City and State		52. Date of report		53. Signature of cemetery	
54. Name of undertaker		55. Address of undertaker		56. City and State		57. Date of report		58. Signature of undertaker	
59. Name of physician		60. Address of physician		61. City and State		62. Date of report		63. Signature of physician	
64. Name of registrar		65. Address of registrar		66. City and State		67. Date of report		68. Signature of registrar	
69. Name of informant		70. Address of informant		71. City and State		72. Date of report		73. Signature of informant	
74. Name of funeral home		75. Address of funeral home		76. City and State		77. Date of report		78. Signature of funeral home	
79. Name of cemetery		80. Address of cemetery		81. City and State		82. Date of report		83. Signature of cemetery	
84. Name of undertaker		85. Address of undertaker		86. City and State		87. Date of report		88. Signature of undertaker	
89. Name of physician		90. Address of physician		91. City and State		92. Date of report		93. Signature of physician	
94. Name of registrar		95. Address of registrar		96. City and State		97. Date of report		98. Signature of registrar	
99. Name of informant		100. Address of informant		101. City and State		102. Date of report		103. Signature of informant	

13185 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 HRS. 15 MINS.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WARWICK AND MEMORIAL HOSPITAL - MEMORIAL AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 316 FAYETTE STREET		4. DATE OF DEATH Month DECEMBER		Day 19	
3. NAME OF DECEASED (Type or print) WARREN		First WARREN		Middle MELLINGER		Last MELLINGER		Year 19 58	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH SEPT. 28, 1869		9. AGE (In years last birthday) 87 8 1/2 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CITY EMPLOYEE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GREENCASTLE, PA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME WILLIAM G. MELLINGER		14. MOTHER'S MAIDEN NAME ADALINE - VIRGINIA HAMILL		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia, Generalized arteriosclerosis DUE TO (c) Diabetic Mellitus		INTERVAL BETWEEN ONSET AND DEATH weeks years		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) CUMBERLAND		(County) MD.		(State) MD.		21. I certify that I attended the deceased from Jan 19 50 to Dec 19 58 that I last saw the deceased alive on Dec 19 58 , and that death occurred at 11:40 P. from the causes and on the date stated above		ADDRESS (Street, city or town, state) 433 Green St. Cumberland, Md.	
ACTUAL SIGNATURE B. M. Schindler		M.D. 12/22/58		PHYSICIAN'S NAME (Type) DR. B. M. SCHINDLER		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/22/58	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Mausoleum		22d. LOCATION (City, town, or county) Cumberland		(State) md.		23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc.		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DEC 23 58		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas		DATE DEC 23 58					

MEDICAL CERTIFICATION

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

13186 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 19 HOURS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EFFIE Middle VIOLA Last MESSMAN				4. DATE OF DEATH Month DEC. Day 16 Year 19 58			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 2, 1889		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME SAMUEL HARDEN (DECEASED)				14. MOTHER'S MAIDEN NAME SARAH MILLER (DECEASED)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or known) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT PATIENTS CHART Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Crisis - Vascular Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/15 , 19 58 , to 12/16 , 19 58 , that I last saw the deceased alive on 12/16 , 19 58 , and that death occurred at 1:10 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Leo H. Ley, Jr.		M.D.		ADDRESS (Street, city or town, state) N. CENTRE ST., CUMBERLAND, MD.		DATE SIGNED 12/18/58	
PHYSICIAN'S NAME (Type) LEO H. LEY, JR., M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/18/58		22c. NAME OF CEMETERY OR CREMATORY Sts. Peter & Paul Cemetery Cumberland Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.				ADDRESS		24a. REC'D BY REGISTRAR DEC 22 1958	
				24b. REGISTRAR'S SIGNATURE Arthur E. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MARYLAND DEPARTMENT OF HEALTH BUREAU OF VITAL RECORDS FEBRUARY 1910

W. M. BOND

W. M. BOND

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13187 CERTIFICATE OF DEATH

13193

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 615 Maryland Avenue				d. STREET ADDRESS 615 Maryland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELIZABETH SARAH MILBURN				4. DATE OF DEATH December 6 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 22, 1884	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Magnolia, West Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Clair R. Flora, 321 Maryland Avenue, Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x Thrombosis DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Thrombosis DUE TO (c) 7 days						INTERVAL BETWEEN ONSET AND DEATH 7 days	
						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 1956 to Dec 6, 1958 , that I last saw the deceased alive on Dec. 4, 1958 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE Clay E. Durrett M.D. Cumberland Md				ADDRESS (Street, city or town, state) 176/58			
PHYSICIAN'S NAME (Type) Clay E. Durrett M.D. 236 Virginia Avenue, Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 8, 1958		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR DEC 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

13188 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 220 Paca Street			
3. NAME OF DECEASED (Type or print) First William Middle Ignatius Last Mills				4. DATE OF DEATH Month 12 Day 24 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 27, 1875		9. AGE (In years last birthday) yrs. 83	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Time Keeper				10b. KIND OF BUSINESS OR INDUSTRY City of Cumb.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Patrick Mills				14. MOTHER'S MAIDEN NAME Margaret Mc Cormick			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Chart	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 year 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12-2 , 19 57 , to 12-24 , 19 58 , that I last saw the deceased alive on 12-23 , 19 58 , and that death occurred at 1:30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE L. Brings				ADDRESS (Street, city or town, state) 57 Green St. Cumberland, Md.			
DATE SIGNED Dec 12-24-58							
PHYSICIAN'S NAME (Type) Lewis Brings, M.D.				57 Green Street Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 27, 1958		22c. NAME OF CEMETERY OR CREMATORY St. Patricks		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR DEC 29 58	
						24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE OF MARYLAND
JAMES BOND

MARYLAND STATE DEPARTMENT OF HEALTH - BASTINOR, 12

13128 CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of witness		12. Signature of coroner	
13. Signature of undertaker		14. Signature of funeral home		15. Signature of cemetery	
16. Signature of church		17. Signature of family		18. Signature of neighbors	
19. Signature of friends		20. Signature of community		21. Signature of society	
22. Signature of association		23. Signature of organization		24. Signature of institution	
25. Signature of government		26. Signature of authority		27. Signature of official	
28. Signature of agent		29. Signature of representative		30. Signature of delegate	
31. Signature of proxy		32. Signature of substitute		33. Signature of alternate	
34. Signature of successor		35. Signature of heir		36. Signature of beneficiary	
37. Signature of legatee		38. Signature of devisee		39. Signature of assignee	
40. Signature of transferee		41. Signature of assignor		42. Signature of grantor	
43. Signature of donor		44. Signature of donee		45. Signature of creditor	
46. Signature of debtor		47. Signature of obligor		48. Signature of obligee	
49. Signature of promisor		50. Signature of promisee		51. Signature of offeror	
52. Signature of offeree		53. Signature of acceptor		54. Signature of acceptor	
55. Signature of acceptor		56. Signature of acceptor		57. Signature of acceptor	
58. Signature of acceptor		59. Signature of acceptor		60. Signature of acceptor	
61. Signature of acceptor		62. Signature of acceptor		63. Signature of acceptor	
64. Signature of acceptor		65. Signature of acceptor		66. Signature of acceptor	
67. Signature of acceptor		68. Signature of acceptor		69. Signature of acceptor	
70. Signature of acceptor		71. Signature of acceptor		72. Signature of acceptor	
73. Signature of acceptor		74. Signature of acceptor		75. Signature of acceptor	
76. Signature of acceptor		77. Signature of acceptor		78. Signature of acceptor	
79. Signature of acceptor		80. Signature of acceptor		81. Signature of acceptor	
82. Signature of acceptor		83. Signature of acceptor		84. Signature of acceptor	
85. Signature of acceptor		86. Signature of acceptor		87. Signature of acceptor	
88. Signature of acceptor		89. Signature of acceptor		90. Signature of acceptor	
91. Signature of acceptor		92. Signature of acceptor		93. Signature of acceptor	
94. Signature of acceptor		95. Signature of acceptor		96. Signature of acceptor	
97. Signature of acceptor		98. Signature of acceptor		99. Signature of acceptor	
100. Signature of acceptor		101. Signature of acceptor		102. Signature of acceptor	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13195

13189 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 FROSTBURG	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CINDY Middle LOU Last MINNICK		4. DATE OF DEATH Month DECEMBER Day 20 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August SEPTEMBER-12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) FROSTBURG, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME CONRAD A. MINNICK		14. MOTHER'S MAIDEN NAME RUTH RAINER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congenital Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Pneumonia INTERVAL BETWEEN ONSET AND DEATH 24 hrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 13, 1958 to Dec 20, 1958 , that I last saw the deceased alive on Dec 20, 1958 , and that death occurred at 9:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Denton Hummel		ADDRESS (Street, city or town, state) 133 Va ave, Cumberland, Md DATE SIGNED 12/21/58	
PHYSICIAN'S NAME (Type) DR. OVERTON HIMMELWRIGHT			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-23-58	
22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park, Frostburg Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home		24a. REC'D BY REGISTRAR DEC 29 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanks			

2061151XV5

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
John Doe		Male		45		Jan 1, 1920		Jan 15, 1965		Home		Heart Disease		Natural		[Signature]		[Signature]	
11. Occupation		12. Education		13. Marital status		14. Usual residence		15. Usual place of work		16. Name of attending physician		17. Name of funeral home		18. Name of cemetery		19. Name of undertaker		20. Name of mortician	
Teacher		High School		Married		Baltimore, MD		Baltimore, MD		Dr. Smith		Doe Funeral Home		Greenwood Cemetery		John Doe		John Doe	
21. Name of informant		22. Relationship to deceased		23. Informant's address		24. Informant's phone		25. Informant's occupation		26. Informant's signature		27. Informant's date		28. Informant's address		29. Informant's phone		30. Informant's occupation	
Jane Doe		Wife		123 Main St		555-1234		Teacher		[Signature]		Jan 10, 1965		123 Main St		555-1234		Teacher	

1. Name of informant
2. Relationship to deceased
3. Informant's address
4. Informant's phone
5. Informant's occupation
6. Informant's signature
7. Informant's date
8. Informant's address
9. Informant's phone
10. Informant's occupation

13190 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va. b. COUNTY Mineral	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgeley, 85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hosp.		d. STREET ADDRESS 15 Potomac Ave.,	
3. NAME OF DECEASED (Type or print) First EDWARD Middle DOUGLAS Last MOON		4. DATE OF DEATH Month Dec. Day 17, Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1894
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired oiler		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.	11. BIRTHPLACE (State or foreign country) Commerce Co. Texas
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME William W. Moon	
14. MOTHER'S MAIDEN NAME Martha Garner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No,	
16. SOCIAL SECURITY NO. 214-07-2143		17. INFORMANT Mrs. Mary E. Moon Address Ridgeley, W. Va. 15 Potomac Ave.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive and arteriosclerotic cardiovascular disease. DUE TO (c) Generalized arteriosclerosis.			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours 10 years ???
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute myocardial infarction, anterior, August, 1956.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1949 , to 17 December 1958 , that I last saw the deceased alive on 17 December 1958 , and that death occurred at 1:50 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Alfred Van Ormer		ADDRESS (Street, city or town, state) 122 So. Centre St., DATE SIGNED 12/18/58	
PHYSICIAN'S NAME (Type) W. A. Van Ormer M. D.		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/20/58	22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park	22d. LOCATION (City, town, or county) (State) Frostburg, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE DEC 22 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13191

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 02 Cumberland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 106 North Mechanic Street			d. STREET ADDRESS 106 N. Mechanic Street		
3. NAME OF DECEASED (Type or print) Alexander Moore			4. DATE OF DEATH December 7 1958		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 13, 1887		9. AGE (In years last birthday) 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Janitor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) St. James, Barbados. W. Indies	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-10-7712		17. INFORMANT Henry L. Davis, Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY Sclerosis DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Benedict Skitarelic M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 7, 1958.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/9/58		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
				22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.			24a. REC'D BY REGISTRAR DEC 10 '58		24b. REGISTRAR'S SIGNATURE Charles S. Haas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13234 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13198

Item 1 Film G237 1-12-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Luke		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) -----		d. STREET ADDRESS Trost Avenue	
3. NAME OF DECEASED (Type or print) WILLIAM JAMES MORGAN		4. DATE OF DEATH Month December Day 5 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 16, 1930
9. AGE (In years last birthday) 28 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Const. Wkr.		10b. KIND OF BUSINESS OR INDUSTRY Tidewater-Hazelwood Const. Mt. Savage, Md	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Thomas Maxr Morgan		14. MOTHER'S MAIDEN NAME Nannje Scott	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Trost Avenue	
17. INFORMANT Mrs. Jean Morgan Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemothorax 9023 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Crushed Chest DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 10 min. 10 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell 58 feet from platform.	
20c. TIME OF INJURY Month, Day, Year 9:30 a. m. Dec 5 1958		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Factory		20f. (City or town) (County) (State) Luke, Alleg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic MD.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Dec. 5, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/8/58	
22c. NAME OF CEMETERY OR CREMATORY St. Luke's Luth. Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DEC 9 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Hafer			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13199

13192 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN TB DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
f. STREET ADDRESS 412 S. Cedar Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William E Middle Mullenax Last Mullenax		4. DATE OF DEATH Month Dec. Day 4 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1922 Aug. 24, 1922
9. AGE (In years last birthday) 36 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10b. KIND OF BUSINESS OR INDUSTRY Ravena Ohio Arsenal	
11. BIRTHPLACE (State or foreign country) Hightown, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hay H. Mullenax		14. MOTHER'S MAIDEN NAME Mary Elizabeth Eye	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WW II		16. SOCIAL SECURITY NO.	
17. INFORMANT Warren R. Mullenax		Address Rt. 1, Ridgeley, W.Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 Acute Hepatic Failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Fatty Infiltration of Liver (c), stating the underlying cause lost. DUE TO (c) Cerebral edema, Marked		INTERVAL BETWEEN ONSET AND DEATH 6 Hrs. 24 Hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral edema, Marked		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DATE SIGNED Dec. 4, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 6, 1958	
22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DEC 9 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

FOR STATE
HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE	
John A. Baker		65	
RESIDENCE		CITY	
1234 Main St.		Baltimore, Md.	
DATE OF DEATH		PLACE OF DEATH	
Jan 1, 1955		Home	
CAUSE OF DEATH		MANNER OF DEATH	
Heart Disease		Natural	
DISEASE OR INJURY		LOCALITY	
Myocardial Infarction		Baltimore, Md.	
SIGNS AND SYMPTOMS		HISTORY	
Chest pain, shortness of breath, sweating		Onset of pain at 10:00 AM, Jan 1, 1955	
TREATMENT		MEDICAL HISTORY	
Aspirin, morphine, oxygen		Hypertension, diabetes	
FAMILY HISTORY		SOCIAL HISTORY	
None		Smoker, 20 years	
OCCUPATION		EDUCATION	
Teacher		High School	
MARITAL STATUS		RELIGION	
Married		Catholic	
SIGNED AND SEALED		DATE	
[Signature]		Jan 1, 1955	

13193 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 1/2 hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital			d. STREET ADDRESS 1212 Lafayette Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Margaret M Neat			4. DATE OF DEATH Month Dec. Day 18 Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 29, 1900		9. AGE (in years last birthday) 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) National, Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William James Evans			14. MOTHER'S MAIDEN NAME Emma Lancaster		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT 1212 Lafayette Avenue Stanley E. Neat, Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic disease (c) stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 2 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an an inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 18, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/21/58	22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.		ADDRESS		24a. REC'D BY REGISTRAR DEC 24 1958 DATE	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanks</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13201

13194 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALEEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. MARYLAND b. COUNTY ALEEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LITTLE ORLEANS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LITTLE ORLEANS	
d. NAME OF HOSPITAL (If not in hospital, give name of institution) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FREDERICK Middle O'BAKER Last O'BAKER		4. DATE OF DEATH Month DECEMBER Day 31 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 16, 1879
9. AGE (In years (or birthday) yrs. 79)		IF UNDER 1 YEAR IF UNDER 24 HRS. Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARETAKER		10b. KIND OF BUSINESS OR INDUSTRY SPORTS CLUB	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HENRY, O' BAKER		14. MOTHER'S MAIDEN NAME MILLER, ELIZABETH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral broncho-pneumonia 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 491X (b) Congestive heart failure (c) _____ INTERVAL BETWEEN ONSET AND DEATH 2 weeks 2 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Perforation of sigmoid - chicken bone - generalized peritonitis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 29, 1958 , to Dec 31, 1958 , that I last saw the deceased alive on Dec. 31, 1958 , and that death occurred at 10:15 P , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Algonquin Hotel, Cumberland, Md. 1/1/59			
ACTUAL SIGNATURE Thomas F. Lewis		M.D. Algonquin Hotel, Cumberland, Md. 1/1/59	
PHYSICIAN'S NAME (Type) THOMAS F. LEWIS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/3/59	
22c. NAME OF CEMETERY OR CREMATORY STS. PETER AND PAUL'S		22d. LOCATION (City, town, or county) (State) CUMBERLAND, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. HAFFER, CUMBERLAND, MARYLAND		ADDRESS DAVEN 6 '59	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

CERTIFICATE OF DEATH

File No.

County

City

State

Age

Sex

Color

Marital Status

Occupation

Place of Birth

Education

Religion

Usual Residence

Place of Death

Time of Death

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Date of Death

Time of Death

Place of Death

Time of Death

Place of Death

Time of Death

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Date of Death

Time of Death

Place of Death

Time of Death

Place of Death

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Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

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Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Date of Death

Time of Death

Place of Death

Time of Death

Place of Death

Time of Death

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

13221 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Westernport	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 103 Philos Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Balangee Orndorff		4. DATE OF DEATH Dec. 14 1958.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 3, 1898
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Church	
11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thompson Orndorff		14. MOTHER'S MAIDEN NAME Sarah E. Albright	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-05-6329	
17. INFORMANT Lola B. Orndorff-Westernport, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Embolus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 15 Min	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 14, 1958 , to Dec. 14, 1958 , that I last saw the deceased on Dec. 14, 1958 , and that death occurred at 12:55 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul R. Wilson		ADDRESS (Street, city or town, state) 111 Ashfield St Piedmont W. Va. DATE SIGNED 12-15-58	
PHYSICIAN'S NAME (Type) Paul R. Wilson M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/17/58	
22c. NAME OF CEMETERY OR CREMATORY Philos		22d. LOCATION (City, town, or county) (State) Westernport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. L. Boal		ADDRESS Westernport, Md.	
24a. REC'D BY REGISTRAR DEC 17 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Hana	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES M. JONES		45		M		W		1913		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
1234 E. BALTIMORE ST.		CLOCK REPAIRER		HEART DISEASE		NATURAL		JAN 15, 1913		CATHOLIC CEMETERY	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		DATE OF MARRIAGE		NAME OF SPOUSE	
JAN 1, 1868		BALTIMORE, MD.		HIGH SCHOOL		MARRIED		JAN 1, 1890		JAMES M. JONES	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DATE OF BURIAL		PLACE OF BURIAL	
JAN 15, 1913		BALTIMORE, MD.		HEART DISEASE		NATURAL		JAN 15, 1913		CATHOLIC CEMETERY	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		DATE OF MARRIAGE		NAME OF SPOUSE	
JAN 1, 1868		BALTIMORE, MD.		HIGH SCHOOL		MARRIED		JAN 1, 1890		JAMES M. JONES	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE PUBLIC HEALTH SERVICE AND THE BUREAU OF VITAL STATISTICS OF THE UNITED STATES DEPARTMENT OF HEALTH.

13195 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 yr. 11 mo. 13 da.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		d. STREET ADDRESS 146 Main St.	
3. NAME OF DECEASED (Type or print) Charles F. Peters		4. DATE OF DEATH Month Dec. Day 13 Year 19 58	
5. SEX M.	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 12, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Stationery store	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Ferdinand Peters		14. MOTHER'S MAIDEN NAME Katherine Wack	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 304	
17. INFORMANT Mrs. Charles F. Peters-Westernport, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 053 Septicemia & Pyelocystitis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 422 Chronic Myocarditis DUE TO (c) 450 General arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 304 Senile psychosis & obesity		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 29, 1958 , to Dec. 13, 1958 , that I last saw the deceased alive on Dec. 12, 1958 , and that death occurred at 0300 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean		ADDRESS (Street, city or town, state) DATE SIGNED 49 Greene St. 12/13/58	
PHYSICIAN'S NAME (Type) James E. McLean, M.D.		49 Greene St. Cumberland, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/15/58	
22c. NAME OF CEMETERY OR CREMATORY Philos		22d. LOCATION (City, town, or county) (State) Westernport Md	
23. FUNERAL DIRECTOR'S SIGNATURE E. J. Bual - Westernport, Md		24a. REC'D BY REGISTRAR DATE DEC 17 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the patient be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the physician, the funeral director should detach page 3 should be detached for use as the burial-transit certificate and return it to the registrar prior to burial, cremation, or removal, and the

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13196 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13204

Reg. Dist. No.

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 8 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Corriganville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Helen L. Middle Poland Last Poland				4. DATE OF DEATH Month Dec. Day 3 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 31, 1907	
9. AGE (in years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 5 Days 19		IF UNDER 24 HRS. Hours 58 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Corriganville, Md.	
						12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Clites				14. MOTHER'S MAIDEN NAME Alice Logsdon			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Lawrence Poland, Corriganville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Tamponade, Intrapericardial							2 hours
DUE TO (b) Rupture of Aorta							2 hours
DUE TO (c) Dissecting aneurysm of Aorta							2 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 4, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 7, 1958		22c. NAME OF CEMETERY OR CREMATORY Porter Cemetery		22d. LOCATION (City, town, or county) (State) Hyndman, Bedford Co. Pa. Rd 1	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Leigler				ADDRESS Hyndman, Pa.		24a. REC'D BY REGISTRAR DATE DEC 8 '58	
						24b. REGISTRAR'S SIGNATURE Arthur L. Hays	

STATE OF MARYLAND
DEPARTMENT OF HEALTH

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STATE OF MARYLAND
DEPARTMENT OF HEALTH
Baltimore

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13197

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 60 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Clement Street		e. STREET ADDRESS 26 Roberts Street	
3. NAME OF DECEASED (Type or print) First Thornton Middle Ellsworth Last Poole		4. DATE OF DEATH Month Dec. Day 22 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1878
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Cherry Run, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Poole		14. MOTHER'S MAIDEN NAME Emma Ritten	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Margaret Poole, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic disease DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 30 in
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour _____ o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED Dec. 22, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-26-58	
22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE DEC 29 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



13198 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 2 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WARWICK AND MEMORIAL HOSPITAL-MEMORIAL AVE.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WILEY FORD W Va 85X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last SHARON E. PORTER			4. DATE OF DEATH Month Day Year DECEMBER 20 19 58				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 26	9. AGE (In years last birthday) yrs. 6	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME ELMER A PORTER				
14. MOTHER'S MAIDEN NAME BERTHA WAGNER			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO.			17. INFORMANT MEMORIAL HOSPITAL CUMBERLAND, MD.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Rheumatic Fever DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral Lobar Pneumonia					INTERVAL BETWEEN ONSET AND DEATH 8 hr.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from Dec 18, 1958 , to Dec 20, 1958 , that I last saw the deceased alive on Dec 20, 1958 , and that death occurred at 1:29 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE L. O. Himmelwright, M.D.			ADDRESS (Street, city or town, state) 133 Va Ave, Cumberland, Md				
PHYSICIAN'S NAME (Type) DR. OVERTON HIMMELWRIGHT			DATE SIGNED 12/20/58				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/22/58		22c. NAME OF CEMETERY OR CREMATORY Resurrection Mausoleum			
22d. LOCATION (City, town, or county) Cumberland		(State) Pa.		22e. ADDRESS And.			
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc. Cumberland, Md.			24a. REC'D BY REGISTRAR DEC 23 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the General Director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13199 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL (If not in rural area, give street address) MEMORIAL HOSPITAL			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE PIKE d. STREET ADDRESS Rt. 3, Rocky Gap Rd. Cumberland e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
3. NAME OF DECEASED (Type or print) First KENNEY Middle RAINES Last RAINES			4. DATE OF DEATH Month DECEMBER Day 8 Year 19 58		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 1, 1871		9. AGE (In years last birthday) 87 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Gen. Farming		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME MARTIN, RAINES		
14. MOTHER'S MAIDEN NAME Cynthia Hedrick			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO. None			17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MARYLAND		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Uremia, Hypertension, C.V. Disease, 1 month DUE TO of Renalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) flours DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from January 5, 1957 , to March 5, 1958 , that I last saw the deceased alive on March 5, 1958 , and that death occurred at 4:50 P. M. from the causes and on the date stated above.					
ACTUAL SIGNATURE B. M. Schindler		ADDRESS (Street, city or town, state) 43 Greene Street, Cumberland, Md.		DATE SIGNED 12/4/58	
PHYSICIAN'S NAME (Type) DR. B. M. SCHINDLER M.D.		43 Greene Street, Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/11/58	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland			24a. REC'D BY REGISTRAR DATE DEC 11 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Huns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13200 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 HRS 50 MINS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WARNICK AND MEMORIAL HOSPITAL-MEMORIAL AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARTIN Middle J. Last REGAN				4. DATE OF DEATH Month DECEMBER 27 Day 19 Year 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-18-1887	
9. AGE (In years last birthday) yrs. 71		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired life insurance asst Supt		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME TIMOTHY REGAN				14. MOTHER'S MAIDEN NAME JANE GREEN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-8566		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 3 hrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug , 19 58 , to Dec , 19 58 , that I last saw the deceased alive on Dec 27 , 19 58 , and that death occurred at 5:50A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 133 Virginia Ave Cumberland, Md. DATE SIGNED Dec. 28, 1958							
ACTUAL SIGNATURE Dr. Overton Himmelwright				M.D. 133 Virginia Ave Cumberland, Md.			
PHYSICIAN'S NAME (Type) DR. OVERTON HIMMELWRIGHT							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/29/58		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				ADDRESS Cumberland Maryland		24a. REC'D BY REGISTRAR DEC 31 '58	
				24b. REGISTRAR'S SIGNATURE Arthur E. Kiser			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13209

13222 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE	
Allegany		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Frostburg		22 Frostburg,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
Son's home - Same as Item #2		1 S. Water Street, Extended	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last		Month Day Year	
Thomas Wesley Richardson		December 17th, 1958	
5. SEX		6. COLOR OR RACE	
Male		White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
		Jan. 22nd, 1884	
9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
74 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Ret.-Coal Miner		Consol. Coal Co.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Maryland		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Thomas Richardson		Nancy V. Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.	
		213-09-6498	
17. INFORMANT		Address	
Charles Richardson		Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic bronchitis DUE TO (c) arterio-sclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 years 12 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1948, to 12-17, 1958, that I last saw the deceased alive on 12-17, 1958, and that death occurred at 12:45 PM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE H.C. Diehl M.D. 39 W. Main St. 12/19/58			
PHYSICIAN'S NAME (Type) H.C. Diehl, M.D. Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		12-20-58	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
F'b'g. Memorial Park		Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Joseph R. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR DATE DEC 22 '58	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and location. The form is oriented vertically on the page.

DEPARTMENT OF HEALTH
BALTIMORE, MARYLAND

13223 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Frostburg, Rt. 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN First W. Middle RITCHIE Last		4. DATE OF DEATH DEC. Month 3 , Day 1958 Year		5. SEX Male		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-29-1898		9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian				10b. KIND OF BUSINESS OR INDUSTRY Elementary school		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME James Ritchie			
14. MOTHER'S MAIDEN NAME Sarah Fisher				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 213-09-6502				17. INFORMANT Mrs. Nellie Ritchie, Frostburg, Md. Rt. 1 Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Silicosis						INTERVAL BETWEEN ONSET AND DEATH 12 month 14 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1 , 19 58 , to Dec 3 , 19 58 , that I last saw the deceased alive on Dec 2 , 19 58 , and that death occurred at 11:40 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE W O M C Lane				ADDRESS (Street, city or town, state) E. Main St., Frostburg, Md. DATE SIGNED Dec 5 1958			
PHYSICIAN'S NAME (Type) W. O. McLane, M. D.				Frostburg, Md. 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-5-58		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, ADDRESS Frostburg, Md.				24a. REC'D BY REGISTRAR DATE DEC 8 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEATH CERTIFICATE

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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PLACE OF DEATH

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13235

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13211

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Flintstone		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Flintstone		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Agnes E Roberts		4. DATE OF DEATH December 13 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1869 9. AGE (In years last birthday) 89 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Artemas, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wesley Collins		14. MOTHER'S MAIDEN NAME Emma Tewell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. H. C. Willison, Flintstone, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C V disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 30 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 904.0 Fracture of rt femur		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell at home	
20c. TIME OF INJURY Month, Day, Year 4:30 p.m. Oct 30 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Flintstone, Md. (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Dec. 13, 1958.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/16/58	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS	
24a. REC'D BY REGISTRAR DEC 22 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

12232

MARYLAND STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12217

Form with multiple sections for medical examination, including fields for patient information, cause of death, and examiner details. The form is partially filled out with handwritten text and includes checkboxes for various conditions.

NAME: [Handwritten Name]
AGE: [Handwritten Age]
SEX: [Handwritten Sex]
RACE: [Handwritten Race]
DATE OF BIRTH: [Handwritten Date]
PLACE OF BIRTH: [Handwritten Place]
OCCUPATION: [Handwritten Occupation]
CAUSE OF DEATH: [Handwritten Cause]
MANNER OF DEATH: [Handwritten Manner]
EXAMINER'S SIGNATURE: [Handwritten Signature]
DATE: [Handwritten Date]

13201 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FLINTSTONE			
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JAMES HILLEARY ROBERTS			4. DATE OF DEATH Month Day Year DECEMBER 28 19 58				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 13, 1885		9. AGE (In years and birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JERRY ROBERTS				14. MOTHER'S MAIDEN NAME NANNETTE NORRIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 192-03-3565		17. INFORMANT Address MEMORIAL HOSPITAL, CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephritis (c) Hypertensive Myocardial Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 72 hours
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/26/58 , 19 58 , to 12/28 , 19 58 , that I last saw the deceased alive on 12/26/58 , 19 58 , and that death occurred at 11:00 AM from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland Md. DATE SIGNED 12/29/58 ACTUAL SIGNATURE DR. R. J. WILLIAMS PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12.31.58		22c. NAME OF CEMETERY OR CREMATORY Piney Plains		22d. LOCATION (City, town, or county) (State) Little Orleans Allegany Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harold J. Stone				ADDRESS Hancock Md		24a. REC'D BY REGISTRAR DATE JAN 6 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1931

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

CERTIFICATE OF DEATH

THE DEATH OF

WILLIAM J. BROWN, JR.

RESIDENT OF

1234 BROADWAY, NEW YORK, N.Y.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE AT DEATH

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

REMARKS

SIGNATURE

DATE

PLACE

Blank form for recording death details, including fields for name, address, date, place, cause, age, sex, race, religion, education, occupation, date of birth, place of birth, date of entry, remarks, signature, date, and place.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Bureau of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13202 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13213

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN lb <u>28 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>		d. STREET ADDRESS <u>Smith Apts. Kelly Blvd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Theodore</u> M <u>Rose</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>31</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 13, 1888</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). <u>Retired Police Officer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>City Police</u>	
11. BIRTHPLACE (State or foreign country) <u>Lehe, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Martin R. Rose</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Sacred Heart Hosp. Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of right Femur</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u> <u>27 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Slipped and Fell at a Friends house (Paca Street)</u>	
20c. TIME OF INJURY Month, Day, Year <u>10:00 a. m. Dec. 3 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Cumberland, Alleg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Jan. 1, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/5/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George, Cumberland, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>JAN 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. F...</u>	

13203 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 9 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK AND MEMORIAL AVES		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ALTA LA VERNE RYAN		4. DATE OF DEATH Month Day Year DECEMBER 30, 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 7, 1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MAGNOLIA, W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEWIS SMX SHOCK		14. MOTHER'S MAIDEN NAME MARY APPOLD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arterio-sclerotic 447X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) vascular disease (uremia) DUE TO (c) Since 9-25-58		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Left nephrectomy for slag horn type stone & function of kidney		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) CUMBERLAND		(County) (State)
21. I certify that I attended the deceased from 9-25-58 , 19 58 , to 12-30 , 19 58 , that I last saw the deceased alive on 12-30 , 19 58 , and that death occurred at 1:15 P.M. from the causes and on the date stated above.		
ACTUAL SIGNATURE W. F. Williams		ADDRESS (Street, city or town, state) Cumberland Md
PHYSICIAN'S NAME (Type) W. F. WILLIAMS		DATE SIGNED 12-31-58

22a. BURIAL, CREMATION, REMOVAL (Specify) Church	22b. DATE THEREOF 1-2-59	22c. NAME OF CEMETERY OR CREMATORY CAMP HILL	22d. LOCATION (City, town, or county) (State) PAW PAW, W. VA.
23. FUNERAL DIRECTOR'S SIGNATURE PARKS FUNERAL HOME		24a. REC'D BY REGISTRAR Arthur E. Hearn	24b. REGISTRAR'S SIGNATURE Arthur E. Hearn
ADDRESS W. Va.		DATE JAN 5 '59	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1082

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

1920

DECEASED
JAMES B. COLEMAN
JAN 10 1920

Name of deceased		JAMES B. COLEMAN	
Age		38	
Sex		Male	
Race		White	
Married		Yes	
Occupation		Carpenter	
Cause of death		Heart disease	
Date of death		Jan 10 1920	
Place of death		Home	
Signature of physician		J. B. Coleman	
Signature of registrar		J. B. Coleman	
Signature of undertaker		J. B. Coleman	
Signature of witness		J. B. Coleman	
Signature of funeral home		J. B. Coleman	
Signature of cemetery		J. B. Coleman	
Signature of church		J. B. Coleman	
Signature of family		J. B. Coleman	
Signature of neighbors		J. B. Coleman	
Signature of friends		J. B. Coleman	
Signature of community		J. B. Coleman	
Signature of state		J. B. Coleman	
Signature of nation		J. B. Coleman	
Signature of world		J. B. Coleman	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1320 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13215

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Memorial Hospital			d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Joseph Raymond Schaidt			4. DATE OF DEATH Month Dec. Day 5 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1958		9. AGE (In years last birthday) yrs. 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	
13. FATHER'S NAME Joseph Robert Schaidt			14. MOTHER'S MAIDEN NAME Merrie Jean Grose		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mr. Joseph Schaidt, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation 467.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tracheal hemorrhage DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH 10-20 Min. 10-20 Min.					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarellic		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarellic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dec. 5, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-8-58		22c. NAME OF CEMETERY OR CREMATORY Oldtown Cemetery	
22d. LOCATION (City, town, or county) Oldtown, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.			ADDRESS 2060286XV6		24a. REC'D BY REGISTRAR DEC 8 '58
					24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

BP

13215

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF VITALS OFFICE		20. SIGNATURE OF HEALTH DEPT.		21. SIGNATURE OF STATE ARCHIVES	
22. SIGNATURE OF COUNTY ARCHIVES		23. SIGNATURE OF LOCAL ARCHIVES		24. SIGNATURE OF LOCAL HEALTH DEPT.	
25. SIGNATURE OF LOCAL VITALS OFFICE		26. SIGNATURE OF LOCAL CORONER		27. SIGNATURE OF LOCAL JURY	
28. SIGNATURE OF LOCAL WITNESSES		29. SIGNATURE OF LOCAL FUNERAL HOME		30. SIGNATURE OF LOCAL BURIAL PLACE	
31. SIGNATURE OF LOCAL VITALS OFFICE		32. SIGNATURE OF LOCAL HEALTH DEPT.		33. SIGNATURE OF LOCAL STATE ARCHIVES	
34. SIGNATURE OF LOCAL COUNTY ARCHIVES		35. SIGNATURE OF LOCAL LOCAL ARCHIVES		36. SIGNATURE OF LOCAL LOCAL HEALTH DEPT.	
37. SIGNATURE OF LOCAL LOCAL VITALS OFFICE		38. SIGNATURE OF LOCAL LOCAL CORONER		39. SIGNATURE OF LOCAL LOCAL JURY	
40. SIGNATURE OF LOCAL LOCAL WITNESSES		41. SIGNATURE OF LOCAL LOCAL FUNERAL HOME		42. SIGNATURE OF LOCAL LOCAL BURIAL PLACE	
43. SIGNATURE OF LOCAL LOCAL VITALS OFFICE		44. SIGNATURE OF LOCAL LOCAL HEALTH DEPT.		45. SIGNATURE OF LOCAL LOCAL STATE ARCHIVES	
46. SIGNATURE OF LOCAL LOCAL COUNTY ARCHIVES		47. SIGNATURE OF LOCAL LOCAL LOCAL ARCHIVES		48. SIGNATURE OF LOCAL LOCAL LOCAL HEALTH DEPT.	
49. SIGNATURE OF LOCAL LOCAL LOCAL VITALS OFFICE		50. SIGNATURE OF LOCAL LOCAL LOCAL CORONER		51. SIGNATURE OF LOCAL LOCAL LOCAL JURY	
52. SIGNATURE OF LOCAL LOCAL LOCAL WITNESSES		53. SIGNATURE OF LOCAL LOCAL LOCAL FUNERAL HOME		54. SIGNATURE OF LOCAL LOCAL LOCAL BURIAL PLACE	
55. SIGNATURE OF LOCAL LOCAL LOCAL VITALS OFFICE		56. SIGNATURE OF LOCAL LOCAL LOCAL HEALTH DEPT.		57. SIGNATURE OF LOCAL LOCAL LOCAL STATE ARCHIVES	
58. SIGNATURE OF LOCAL LOCAL LOCAL COUNTY ARCHIVES		59. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL ARCHIVES		60. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL HEALTH DEPT.	
61. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL VITALS OFFICE		62. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL CORONER		63. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL JURY	
64. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL WITNESSES		65. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL FUNERAL HOME		66. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL BURIAL PLACE	
67. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL VITALS OFFICE		68. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL HEALTH DEPT.		69. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL STATE ARCHIVES	
70. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL COUNTY ARCHIVES		71. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL ARCHIVES		72. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL HEALTH DEPT.	
73. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL VITALS OFFICE		74. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL CORONER		75. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL JURY	
76. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL WITNESSES		77. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL FUNERAL HOME		78. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL BURIAL PLACE	
79. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL VITALS OFFICE		80. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL HEALTH DEPT.		81. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL STATE ARCHIVES	
82. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL COUNTY ARCHIVES		83. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL ARCHIVES		84. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL HEALTH DEPT.	
85. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL VITALS OFFICE		86. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL CORONER		87. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL JURY	
88. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL WITNESSES		89. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL FUNERAL HOME		90. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL BURIAL PLACE	
91. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL VITALS OFFICE		92. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL HEALTH DEPT.		93. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL STATE ARCHIVES	
94. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL COUNTY ARCHIVES		95. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL ARCHIVES		96. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL HEALTH DEPT.	
97. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL VITALS OFFICE		98. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL CORONER		99. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL JURY	
100. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL WITNESSES		101. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL FUNERAL HOME		102. SIGNATURE OF LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL LOCAL BURIAL PLACE	

13205 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8, 9 Film G237 1-5-59 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penn. b. COUNTY West Moreland ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b West Newton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital-DOA		d. STREET ADDRESS 203 Vine St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Joseph Fisher Scholl		4. DATE OF DEATH Dec. 12 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 30, 1911
9. AGE (In years, day, month, year) 47 46 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supt.		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) West Newton, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Jasper T. Scholl		14. MOTHER'S MAIDEN NAME Edith Hoy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 191-03-6997	
17. INFORMANT Mr. Earl Zimmerman		Address West Newton, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Skull DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile Accident	
20c. TIME OF INJURY Month, Day, Year 12:45 a. m. Dec. 12 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) West Newton, Alleg. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Dec. 12, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/15/1958	
22c. NAME OF CEMETERY OR CREMATORY West Newton		22d. LOCATION (City, town, or county) (State) West Newton, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DEC 15 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Huns</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13205 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

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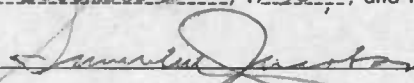
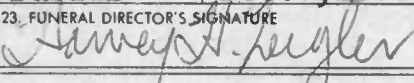
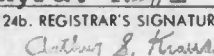
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13206 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WARWICK AND MEMORIAL HOSPITAL- MEMORIAL AVE.				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X ELLERSLIE			
3. NAME OF DECEASED (Type or print) First Middle Last JESSE A. SEE				4. DATE OF DEATH Month Day Year DECEMBER 6 1958			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 29	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Celanese Employee				10b. KIND OF BUSINESS OR INDUSTRY Celanese		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
13. FATHER'S NAME JOHN SEE				14. MOTHER'S MAIDEN NAME SALLY ROSE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-07-1569		17. INFORMANT MEMORIAL HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Left Centricular Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Coronary Arteriosclerosis DUE TO (c) Myocardial Fibrosis						INTERVAL BETWEEN ONSET AND DEATH 40 hr. ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Saddle Embolus (iliacs)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Cumberland, Pa.				20g. (County) Bedford		20h. (State) Pa.	
21. I certify that I attended the deceased from Dec. 4 1958 , to December 6 1958 , that I last saw the deceased alive on December 5 1958 , and that death occurred at 1:05 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE 				ADDRESS (Street, city or town, state) 50 Pershing St. Cumberland, Maryland			
DATE SIGNED 12/6/58							
PHYSICIAN'S NAME (Type) DR. S. M. JACOBSON							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 8, 1958		22c. NAME OF CEMETERY OR CREMATORY Porter Cemetery		22d. LOCATION (City, town, or county) (State) Hyndman, Pa. RD #1 Bedford	
23. FUNERAL DIRECTOR'S SIGNATURE 				ADDRESS Hyndman, Pa.		24a. REC'D BY REGISTRAR DATE DEC 11 '58	
				24b. REGISTRAR'S SIGNATURE 			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13207 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital				e. STREET ADDRESS Ellerslie			
3. NAME OF DECEASED (Type or print) Catherine Elizabeth Simpkins				4. DATE OF DEATH Month December Day 7 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 29, 1873	
9. AGE (In years, last birthday) 84		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Cove, Garrett Co., Md.			
11. BIRTHPLACE (State or foreign country) Cove, Garrett Co., Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Kalbfleisch				14. MOTHER'S MAIDEN NAME Elizabeth Ringler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None			
17. INFORMANT Mr. Charles E. Simpkins, Ellerslie, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Longestroke Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis - Generalized DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 1 wk.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12-7 , 19 58 , to 12-7 , 19 58 , that I last saw the deceased alive on 12-7 , 19 58 , and that death occurred at 11:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 441 N. Center St. Hyndman, Pa. DATE SIGNED 12-8-58							
ACTUAL SIGNATURE William P. James M.D.				PHYSICIAN'S NAME (Type) William P. James Cumberland Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 10, 1958		22c. NAME OF CEMETERY OR CREMATORY Porter Cemetery		22d. LOCATION (City, town, or county) (State) Hyndman, Pa. RD#1	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kraus				24a. REC'D BY REGISTRAR DATE DEC 11 '58			
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

1231

12307 CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13224 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13219

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DONNA LEE SLOAN		4. DATE OF DEATH 12/22/1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 11th. 1942
9. AGE (in years last birthday) 16 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Student, Valley High School	
11. BIRTHPLACE (State or foreign country) Lonaconing, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Sloan		14. MOTHER'S MAIDEN NAME Marselle Allen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Charles Sloan, Lonaconing, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LACERATED Brain 825x DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture Left Skull (c) Fracture Left Skull cause lost.		INTERVAL BETWEEN ONSET AND DEATH 1 hr 9 min " "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile accident - Highway Rt 36	
20c. TIME OF INJURY Month, Day, Year 10:15 a. m. Dec 22 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Near Lonaconing Allegany Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE WOM Lane		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WOM LANE MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Dec 23 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/25/1958	
22c. NAME OF CEMETERY OR CREMATORY Old Coney Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN		ADDRESS , Lonaconing, MD.	
24a. REC'D BY REGISTRAR DEC 29 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
1900 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
JAMES M. JONES		35		Male		White		Roman Catholic	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
1000 North Avenue		April 15, 1900		Home		Typhoid Fever		Natural	
OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		TREATMENT	
Clerk		High School		Married		Typhoid Fever		Physician	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
April 15, 1865		Maryland		April 15, 1900		Home		Typhoid Fever	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER	
April 15, 1900		Home		Typhoid Fever		Natural		J. M. Jones	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER	
April 15, 1900		Home		Typhoid Fever		Natural		J. M. Jones	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13236 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13220

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONA CONING	c. LENGTH OF STAY IN 1b 58yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Detmold Street		d. STREET ADDRESS Detmold Street	
3. NAME OF DECEASED (Type or print) GEORGE First Middle Last		4. DATE OF DEATH Month December Day 28 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/20/1900
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
None		None	
11. BIRTHPLACE (State or foreign country) Lonaconing, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Stafford		14. MOTHER'S MAIDEN NAME Catherine Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes War 1&2		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Elsie Maund, Monnesan, PA.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE WOMcLane		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) WOMcLANE MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Jan 3 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/4/1959	22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery	22d. LOCATION (City, town, or county) (State) Moscow, MD.
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN		ADDRESS LONA CONING, MD.	
24a. REC'D BY REGISTRAR JAN 5 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Evans	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10020

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
1933 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race	
John Doe		45		Male		White	
Residence		Occupation		Cause of Death		Date of Death	
123 Main St, Baltimore, Md.		Teacher		Heart Disease		Jan 15, 1933	
Physician		Medical Examiner		Hospital		Burial Place	
Dr. J. Smith		Dr. A. Jones		St. Mary's Hospital		Catholic Cemetery	
Signature of Physician		Signature of Medical Examiner		Signature of Hospital		Signature of Burial Place	
[Signature]		[Signature]		[Signature]		[Signature]	
Witness		Witness		Witness		Witness	
[Signature]		[Signature]		[Signature]		[Signature]	

1

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND HEALTH ACT OF 1920, AS AMENDED BY THE ACT OF 1922, 1924, 1926, 1928, 1930, 1932, 1934, 1936, 1938, 1940, 1942, 1944, 1946, 1948, 1950, 1952, 1954, 1956, 1958, 1960, 1962, 1964, 1966, 1968, 1970, 1972, 1974, 1976, 1978, 1980, 1982, 1984, 1986, 1988, 1990, 1992, 1994, 1996, 1998, 2000, 2002, 2004, 2006, 2008, 2010, 2012, 2014, 2016, 2018, 2020.

13225 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN 1b Lifetime d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 54 E. College Avenue		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg d. STREET ADDRESS 54 E. College Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARY ANN STARKEY		4. DATE OF DEATH Month Day Year 12 30 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 15, 1882
9. AGE (In years lost birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homework		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Eckhart, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Harris		14. MOTHER'S MAIDEN NAME Katherine Cross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Oliver Johnson, 54 E. College Ave.,		Address Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Hypertension DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio Vascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 1 year Several years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 30, 1958 , to Dec 30, 1958 , that I last saw the deceased alive on Dec 30, 1958 , and that death occurred at 8:30 P. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE WOMC Lane PHYSICIAN'S NAME (Type) WOMC Lane MD		ADDRESS (Street, city or town, state) Frostburg Md. DATE SIGNED Dec 31 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-2-1959	
22c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery		22d. LOCATION (City, town, or county) (State) Eckhart Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul H. Montecant		24a. REC'D BY REGISTRAR JAN 5 '59	
23. FUNERAL HOME 23 E. Main, Frostburg, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13222

13208 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS 16 N. Waverly Terrace	
3. NAME OF DECEASED (Type or print) Annie Swankhaus		4. DATE OF DEATH December 16 Day 16 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1877
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry Swankhaus (Deceased)	
14. MOTHER'S MAIDEN NAME Katherine Swankhaus		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Patients Chart Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident, small, involving the Hypothalamus DUE TO (b) Cerebral and Generalized Arteriosclerosis DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Malnutrition and anemia secondary to Diagnosis #1.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from December 10, 1958 , to December 16, 1958 , that I last saw the deceased alive on December 16, 1958 , and that death occurred on 6:55 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Wyand P. Doerner Jr.		ADDRESS (Street, city or town, state) Algonquin Hotel, Cumberland, Md. DATE SIGNED 12-17-58	
PHYSICIAN'S NAME (Type) Wyand Doerner Jr. M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Dec 19, 1958	22c. NAME OF CEMETERY OR CREMATORY St. Peter + Paul Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland Allegany Md
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein ADDRESS Cumberland Md		24a. REC'D BY REGISTRAR DEC 22 1958	24b. REGISTRAR'S SIGNATURE Arthur S. Huns

1884

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

STATE DEPARTMENT OF HEALTH

Form No. 1

NAME OF PATIENT

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

RESIDENCE

DATE OF ADMISSION

NAME OF PHYSICIAN

NAME OF HOSPITAL

DATE OF EXAMINATION

NAME OF PHYSICIAN

NAME OF HOSPITAL

DATE OF EXAMINATION

NAME OF PHYSICIAN

DATE OF EXAMINATION

NAME OF PHYSICIAN

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DATE OF EXAMINATION

NAME OF PHYSICIAN

NAME OF HOSPITAL

13237 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eckhart		c. LENGTH OF STAY IN 1b 25 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Eckhart		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle E. Last TAYLOR				4. DATE OF DEATH Month Dec. Day 3 Year 19 58			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-4-1884	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 3 Days 3 Hours 19 Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME supervisor Frederick Taylor				14. MOTHER'S MAIDEN NAME Lucinda Rector			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-09-6608		17. INFORMANT Mrs. Maude J. Taylor, Eckhart, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary Sclerosis (c) 14.000						INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 17, 1958 to Dec 3, 1958 , that I last saw the deceased alive on Dec 1, 1958 , and that death occurred at 2:00 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE W O McLane M.D.				ADDRESS (Street, city or town, state) E. Main St., Dec 5, Frostburg, Md. 1958			
PHYSICIAN'S NAME (Type) W. O. McLane, M. D.				Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-6-58		22c. NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR DATE DEC 8 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Kraw			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13238 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oldtown</u>				c. LENGTH OF STAY IN 1b <u>41 years</u> X			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Route 1,</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ZELL</u> Middle <u>L.</u> Last <u>TETER</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>22,</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18, 1876</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob S. Teter</u>				14. MOTHER'S MAIDEN NAME <u>Sadie Lantz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Margaret Teter, Oldtown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis Chronic</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>3-5 yr.</u> <u>10*20 Yr</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-15-58</u> , 19 <u>58</u> to <u>12-23-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12-15-58</u> , 19 <u>58</u> , and that death occurred at <u>10 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Paw Paw, W. Va.</u> DATE SIGNED <u>12-23-58,</u>							
ACTUAL SIGNATURE <u>J. T. Armstrong</u>		M.D. <u>Paw Paw, W. Va.</u>					
PHYSICIAN'S NAME (Type) <u>A. T. Armstrong</u>		<u>Paw Paw, W. Va.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/26/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oldtown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Oldtown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Kight</u>				ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 29 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Cashier & House</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Date of registration	
John Doe		Male		White		1900-01-01		New York, N.Y.		1950-01-01		New York, N.Y.		Heart Disease		Natural		John Doe, M.D.		John Doe, Registrar		1950-01-01	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Telephone		20. Signature of informant		21. Signature of registrar		22. Date of registration		23. Signature of registrar		24. Date of registration	
John Doe		Son		123 Main St.		New York		N.Y.		10001		(212) 123-4567		John Doe		John Doe, Registrar		1950-01-01		John Doe, Registrar		1950-01-01	
25. Name of informant		26. Relationship		27. Address		28. City		29. State		30. Zip		31. Telephone		32. Signature of informant		33. Signature of registrar		34. Date of registration		35. Signature of registrar		36. Date of registration	
John Doe		Son		123 Main St.		New York		N.Y.		10001		(212) 123-4567		John Doe		John Doe, Registrar		1950-01-01		John Doe, Registrar		1950-01-01	

13209 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 4 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND d. STREET ADDRESS 216 SCHLEY STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GRACE Middle E. Last TRIEBER		4. DATE OF DEATH Month DECEMBER Day 14 Year 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 31, 1880
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months 14 Days 19 Hours 58 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME LOUIS SOYSTER		14. MOTHER'S MAIDEN NAME CAROLINE MAGRUDER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiac - Vascular DUE TO (c) Disease		INTERVAL BETWEEN ONSET AND DEATH 4	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/10 , 19 58 , to 12/14 , 19 58 , that I last saw the deceased alive on 12/14 , 19 58 , and that death occurred at 2:53 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Leo H. Ley Jr		ADDRESS (Street, city or town, state) 456 N. Centre St. Cumberland, Md.	
PHYSICIAN'S NAME (Type) DR. LEO H. LEY		DATE SIGNED 12/16/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/17/58	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox		ADDRESS Cumberland Maryland	
24a. REC'D BY REGISTRAR DEC 19 58		24b. REGISTRAR'S SIGNATURE Arthur E. Klaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

WILLIAM BOND

NAME OF DECEASED		WILLIAM BOND	
AGE		65	
SEX		Male	
RACE		White	
DATE OF BIRTH		JAN 15 1880	
PLACE OF BIRTH		BALTIMORE, MARYLAND	
OCCUPATION		Carpenter	
MARITAL STATUS		Married	
DATE OF DEATH		JAN 25 1945	
PLACE OF DEATH		BALTIMORE, MARYLAND	
CAUSE OF DEATH		Heart Disease	
MANNER OF DEATH		Natural	
SIGNATURE OF PHYSICIAN		[Signature]	
SIGNATURE OF REGISTRAR		[Signature]	
DATE OF REGISTRATION		JAN 26 1945	
PLACE OF REGISTRATION		BALTIMORE, MARYLAND	

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13226
13210 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Item 3 FilmG239 2-20-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital			d. STREET ADDRESS 1209 Lexington Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Carl Lee Middle Wesley Last Turner			4. DATE OF DEATH Month Dec. Day 16 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1901		9. AGE (In years last birthday) 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Charles Turner		
14. MOTHER'S MAIDEN NAME Anna			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes War I		
16. SOCIAL SECURITY NO. 220-10-2420		17. INFORMANT Address Mrs. Carl L. Turner, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Sclerosis (c) 420.1 DUE TO (c) 420.1 DUE TO					INTERVAL BETWEEN ONSET AND DEATH 1 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Asthma					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. Benedict Skitarelic		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Dec. 16, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-20-58		22c. NAME OF CEMETERY OR CREMATORY Rest Lawn Gardens	
22d. LOCATION (City, town, or county) Cumberland, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.			24. REC'D BY REGISTRAR DATE DEC 22 '58		
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
1931 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED
RESIDENCE
CITY
COUNTY
STATE

1. NAME OF DECEASED		2. RESIDENCE		3. CITY		4. COUNTY		5. STATE	
6. DATE OF DEATH		7. TIME OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH	
11. SIGNATURE OF EXAMINER		12. SIGNATURE OF WITNESS		13. SIGNATURE OF JURY		14. SIGNATURE OF CORONER		15. SIGNATURE OF MINISTER	
16. SIGNATURE OF CLERK		17. SIGNATURE OF NURSE		18. SIGNATURE OF DOCTOR		19. SIGNATURE OF CHURCH		20. SIGNATURE OF FUNERAL HOME	
21. SIGNATURE OF BURIAL SOCIETY		22. SIGNATURE OF CEMETERY		23. SIGNATURE OF INTERMENT		24. SIGNATURE OF RECORDS		25. SIGNATURE OF ARCHIVES	
26. SIGNATURE OF VITALS		27. SIGNATURE OF STATISTICS		28. SIGNATURE OF DEMOGRAPHICS		29. SIGNATURE OF EPIDEMIOLOGY		30. SIGNATURE OF PUBLIC HEALTH	
31. SIGNATURE OF MEDICAL OFFICER		32. SIGNATURE OF HEALTH DEPT		33. SIGNATURE OF BALTIMORE		34. SIGNATURE OF MARYLAND		35. SIGNATURE OF UNITED STATES	
36. SIGNATURE OF DEPARTMENT		37. SIGNATURE OF DIVISION		38. SIGNATURE OF SECTION		39. SIGNATURE OF BRANCH		40. SIGNATURE OF OFFICE	
41. SIGNATURE OF UNIT		42. SIGNATURE OF TEAM		43. SIGNATURE OF GROUP		44. SIGNATURE OF SQUAD		45. SIGNATURE OF PLATOON	
46. SIGNATURE OF COMPANION		47. SIGNATURE OF DETACHMENT		48. SIGNATURE OF BATTALION		49. SIGNATURE OF REGIMENT		50. SIGNATURE OF DIVISION	
51. SIGNATURE OF CORPS		52. SIGNATURE OF ARMY		53. SIGNATURE OF NAVY		54. SIGNATURE OF AIR FORCE		55. SIGNATURE OF MARINE CORPS	
56. SIGNATURE OF COAST GUARD		57. SIGNATURE OF NATIONAL GUARD		58. SIGNATURE OF RESERVE		59. SIGNATURE OF MILITIA		60. SIGNATURE OF VOLUNTEER	
61. SIGNATURE OF CITIZEN		62. SIGNATURE OF SOLDIER		63. SIGNATURE OF SEAMAN		64. SIGNATURE OF AIRMAN		65. SIGNATURE OF MARINE	
66. SIGNATURE OF NAVY		67. SIGNATURE OF AIR FORCE		68. SIGNATURE OF MARINE CORPS		69. SIGNATURE OF COAST GUARD		70. SIGNATURE OF NATIONAL GUARD	
71. SIGNATURE OF RESERVE		72. SIGNATURE OF MILITIA		73. SIGNATURE OF VOLUNTEER		74. SIGNATURE OF CITIZEN		75. SIGNATURE OF SOLDIER	
76. SIGNATURE OF SEAMAN		77. SIGNATURE OF AIRMAN		78. SIGNATURE OF MARINE		79. SIGNATURE OF NAVY		80. SIGNATURE OF AIR FORCE	
81. SIGNATURE OF MARINE CORPS		82. SIGNATURE OF COAST GUARD		83. SIGNATURE OF NATIONAL GUARD		84. SIGNATURE OF RESERVE		85. SIGNATURE OF MILITIA	
86. SIGNATURE OF VOLUNTEER		87. SIGNATURE OF CITIZEN		88. SIGNATURE OF SOLDIER		89. SIGNATURE OF SEAMAN		90. SIGNATURE OF AIRMAN	
91. SIGNATURE OF MARINE		92. SIGNATURE OF NAVY		93. SIGNATURE OF AIR FORCE		94. SIGNATURE OF MARINE CORPS		95. SIGNATURE OF COAST GUARD	
96. SIGNATURE OF NATIONAL GUARD		97. SIGNATURE OF RESERVE		98. SIGNATURE OF MILITIA		99. SIGNATURE OF VOLUNTEER		100. SIGNATURE OF CITIZEN	
101. SIGNATURE OF SOLDIER		102. SIGNATURE OF SEAMAN		103. SIGNATURE OF AIRMAN		104. SIGNATURE OF MARINE		105. SIGNATURE OF NAVY	
106. SIGNATURE OF AIR FORCE		107. SIGNATURE OF MARINE CORPS		108. SIGNATURE OF COAST GUARD		109. SIGNATURE OF NATIONAL GUARD		110. SIGNATURE OF RESERVE	
111. SIGNATURE OF MILITIA		112. SIGNATURE OF VOLUNTEER		113. SIGNATURE OF CITIZEN		114. SIGNATURE OF SOLDIER		115. SIGNATURE OF SEAMAN	
116. SIGNATURE OF AIRMAN		117. SIGNATURE OF MARINE		118. SIGNATURE OF NAVY		119. SIGNATURE OF AIR FORCE		120. SIGNATURE OF MARINE CORPS	
121. SIGNATURE OF COAST GUARD		122. SIGNATURE OF NATIONAL GUARD		123. SIGNATURE OF RESERVE		124. SIGNATURE OF MILITIA		125. SIGNATURE OF VOLUNTEER	
126. SIGNATURE OF CITIZEN		127. SIGNATURE OF SOLDIER		128. SIGNATURE OF SEAMAN		129. SIGNATURE OF AIRMAN		130. SIGNATURE OF MARINE	
131. SIGNATURE OF NAVY		132. SIGNATURE OF AIR FORCE		133. SIGNATURE OF MARINE CORPS		134. SIGNATURE OF COAST GUARD		135. SIGNATURE OF NATIONAL GUARD	
136. SIGNATURE OF RESERVE		137. SIGNATURE OF MILITIA		138. SIGNATURE OF VOLUNTEER		139. SIGNATURE OF CITIZEN		140. SIGNATURE OF SOLDIER	
141. SIGNATURE OF SEAMAN		142. SIGNATURE OF AIRMAN		143. SIGNATURE OF MARINE		144. SIGNATURE OF NAVY		145. SIGNATURE OF AIR FORCE	
146. SIGNATURE OF MARINE CORPS		147. SIGNATURE OF COAST GUARD		148. SIGNATURE OF NATIONAL GUARD		149. SIGNATURE OF RESERVE		150. SIGNATURE OF MILITIA	
151. SIGNATURE OF VOLUNTEER		152. SIGNATURE OF CITIZEN		153. SIGNATURE OF SOLDIER		154. SIGNATURE OF SEAMAN		155. SIGNATURE OF AIRMAN	
156. SIGNATURE OF MARINE		157. SIGNATURE OF NAVY		158. SIGNATURE OF AIR FORCE		159. SIGNATURE OF MARINE CORPS		160. SIGNATURE OF COAST GUARD	
161. SIGNATURE OF NATIONAL GUARD		162. SIGNATURE OF RESERVE		163. SIGNATURE OF MILITIA		164. SIGNATURE OF VOLUNTEER		165. SIGNATURE OF CITIZEN	
166. SIGNATURE OF SOLDIER		167. SIGNATURE OF SEAMAN		168. SIGNATURE OF AIRMAN		169. SIGNATURE OF MARINE		170. SIGNATURE OF NAVY	
171. SIGNATURE OF AIR FORCE		172. SIGNATURE OF MARINE CORPS		173. SIGNATURE OF COAST GUARD		174. SIGNATURE OF NATIONAL GUARD		175. SIGNATURE OF RESERVE	
176. SIGNATURE OF MILITIA		177. SIGNATURE OF VOLUNTEER		178. SIGNATURE OF CITIZEN		179. SIGNATURE OF SOLDIER		180. SIGNATURE OF SEAMAN	
181. SIGNATURE OF AIRMAN		182. SIGNATURE OF MARINE		183. SIGNATURE OF NAVY		184. SIGNATURE OF AIR FORCE		185. SIGNATURE OF MARINE CORPS	
186. SIGNATURE OF COAST GUARD		187. SIGNATURE OF NATIONAL GUARD		188. SIGNATURE OF RESERVE		189. SIGNATURE OF MILITIA		190. SIGNATURE OF VOLUNTEER	
191. SIGNATURE OF CITIZEN		192. SIGNATURE OF SOLDIER		193. SIGNATURE OF SEAMAN		194. SIGNATURE OF AIRMAN		195. SIGNATURE OF MARINE	
196. SIGNATURE OF NAVY		197. SIGNATURE OF AIR FORCE		198. SIGNATURE OF MARINE CORPS		199. SIGNATURE OF COAST GUARD		200. SIGNATURE OF NATIONAL GUARD	
201. SIGNATURE OF RESERVE		202. SIGNATURE OF MILITIA		203. SIGNATURE OF VOLUNTEER		204. SIGNATURE OF CITIZEN		205. SIGNATURE OF SOLDIER	
206. SIGNATURE OF SEAMAN		207. SIGNATURE OF AIRMAN		208. SIGNATURE OF MARINE		209. SIGNATURE OF NAVY		210. SIGNATURE OF AIR FORCE	
211. SIGNATURE OF MARINE CORPS		212. SIGNATURE OF COAST GUARD		213. SIGNATURE OF NATIONAL GUARD		214. SIGNATURE OF RESERVE		215. SIGNATURE OF MILITIA	
216. SIGNATURE OF VOLUNTEER		217. SIGNATURE OF CITIZEN		218. SIGNATURE OF SOLDIER		219. SIGNATURE OF SEAMAN		220. SIGNATURE OF AIRMAN	
221. SIGNATURE OF MARINE		222. SIGNATURE OF NAVY		223. SIGNATURE OF AIR FORCE		224. SIGNATURE OF MARINE CORPS		225. SIGNATURE OF COAST GUARD	
226. SIGNATURE OF NATIONAL GUARD		227. SIGNATURE OF RESERVE		228. SIGNATURE OF MILITIA		229. SIGNATURE OF VOLUNTEER		230. SIGNATURE OF CITIZEN	
231. SIGNATURE OF SOLDIER		232. SIGNATURE OF SEAMAN		233. SIGNATURE OF AIRMAN		234. SIGNATURE OF MARINE		235. SIGNATURE OF NAVY	
236. SIGNATURE OF AIR FORCE		237. SIGNATURE OF MARINE CORPS		238. SIGNATURE OF COAST GUARD		239. SIGNATURE OF NATIONAL GUARD		240. SIGNATURE OF RESERVE	
241. SIGNATURE OF MILITIA		242. SIGNATURE OF VOLUNTEER		243. SIGNATURE OF CITIZEN		244. SIGNATURE OF SOLDIER		245. SIGNATURE OF SEAMAN	
246. SIGNATURE OF AIRMAN		247. SIGNATURE OF MARINE		248. SIGNATURE OF NAVY		249. SIGNATURE OF AIR FORCE		250. SIGNATURE OF MARINE CORPS	
251. SIGNATURE OF COAST GUARD		252. SIGNATURE OF NATIONAL GUARD		253. SIGNATURE OF RESERVE		254. SIGNATURE OF MILITIA		255. SIGNATURE OF VOLUNTEER	
256. SIGNATURE OF CITIZEN		257. SIGNATURE OF SOLDIER		258. SIGNATURE OF SEAMAN		259. SIGNATURE OF AIRMAN		260. SIGNATURE OF MARINE	
261. SIGNATURE OF NAVY		262. SIGNATURE OF AIR FORCE		263. SIGNATURE OF MARINE CORPS		264. SIGNATURE OF COAST GUARD		265. SIGNATURE OF NATIONAL GUARD	
266. SIGNATURE OF RESERVE		267. SIGNATURE OF MILITIA		268. SIGNATURE OF VOLUNTEER		269. SIGNATURE OF CITIZEN		270. SIGNATURE OF SOLDIER	
271. SIGNATURE OF SEAMAN		272. SIGNATURE OF AIRMAN		273. SIGNATURE OF MARINE		274. SIGNATURE OF NAVY		275. SIGNATURE OF AIR FORCE	
276. SIGNATURE OF MARINE CORPS		277. SIGNATURE OF COAST GUARD		278. SIGNATURE OF NATIONAL GUARD		279. SIGNATURE OF RESERVE		280. SIGNATURE OF MILITIA	
281. SIGNATURE OF VOLUNTEER		282. SIGNATURE OF CITIZEN		283. SIGNATURE OF SOLDIER		284. SIGNATURE OF SEAMAN		285. SIGNATURE OF AIRMAN	
286. SIGNATURE OF MARINE		287. SIGNATURE OF NAVY		288. SIGNATURE OF AIR FORCE		289. SIGNATURE OF MARINE CORPS		290. SIGNATURE OF COAST GUARD	
291. SIGNATURE OF NATIONAL GUARD		292. SIGNATURE OF RESERVE		293. SIGNATURE OF MILITIA		294. SIGNATURE OF VOLUNTEER		295. SIGNATURE OF CITIZEN	
296. SIGNATURE OF SOLDIER		297. SIGNATURE OF SEAMAN		298. SIGNATURE OF AIRMAN		299. SIGNATURE OF MARINE		300. SIGNATURE OF NAVY	
301. SIGNATURE OF AIR FORCE		302. SIGNATURE OF MARINE CORPS		303. SIGNATURE OF COAST GUARD		304. SIGNATURE OF NATIONAL GUARD		305. SIGNATURE OF RESERVE	
306. SIGNATURE OF MILITIA		307. SIGNATURE OF VOLUNTEER		308. SIGNATURE OF CITIZEN		309. SIGNATURE OF SOLDIER		310. SIGNATURE OF SEAMAN	
311. SIGNATURE OF AIRMAN		312. SIGNATURE OF MARINE		313. SIGNATURE OF NAVY		314. SIGNATURE OF AIR FORCE		315. SIGNATURE OF MARINE CORPS	
316. SIGNATURE OF COAST GUARD		317. SIGNATURE OF NATIONAL GUARD		318. SIGNATURE OF RESERVE		319. SIGNATURE OF MILITIA		320. SIGNATURE OF VOLUNTEER	
321. SIGNATURE OF CITIZEN		322. SIGNATURE OF SOLDIER		323. SIGNATURE OF SEAMAN		324. SIGNATURE OF AIRMAN		325. SIGNATURE OF MARINE	
326. SIGNATURE OF NAVY		327. SIGNATURE OF AIR FORCE		328. SIGNATURE OF MARINE CORPS		329. SIGNATURE OF COAST GUARD		330. SIGNATURE OF NATIONAL GUARD	
331. SIGNATURE OF RESERVE		332. SIGNATURE OF MILITIA		333. SIGNATURE OF VOLUNTEER		334. SIGNATURE OF CITIZEN		335. SIGNATURE OF SOLDIER	
336. SIGNATURE OF SEAMAN		337. SIGNATURE OF AIRMAN		338. SIGNATURE OF MARINE		339. SIGNATURE OF NAVY		340. SIGNATURE OF AIR FORCE	
341. SIGNATURE OF MARINE CORPS		342. SIGNATURE OF COAST GUARD		343. SIGNATURE OF NATIONAL GUARD		344. SIGNATURE OF RESERVE		345. SIGNATURE OF MILITIA	
346. SIGNATURE OF VOLUNTEER		347. SIGNATURE OF CITIZEN		348. SIGNATURE OF SOLDIER		349. SIGNATURE OF SEAMAN		350. SIGNATURE OF AIRMAN	
351. SIGNATURE OF MARINE		352. SIGNATURE OF NAVY		353. SIGNATURE OF AIR FORCE		354. SIGNATURE OF MARINE CORPS		355. SIGNATURE OF COAST GUARD	
356. SIGNATURE OF NATIONAL GUARD		357. SIGNATURE OF RESERVE		358. SIGNATURE OF MILITIA		359. SIGNATURE OF VOLUNTEER		360. SIGNATURE OF CITIZEN	
361. SIGNATURE OF SOLDIER		362. SIGNATURE OF SEAMAN		363. SIGNATURE OF AIRMAN		364. SIGNATURE OF MARINE		365. SIGNATURE OF NAVY	
366. SIGNATURE OF AIR FORCE		367. SIGNATURE OF MARINE CORPS		368. SIGNATURE OF COAST GUARD		369. SIGNATURE OF NATIONAL GUARD		370. SIGNATURE OF RESERVE	
371. SIGNATURE OF MILITIA		372. SIGNATURE OF VOLUNTEER		373. SIGNATURE OF CITIZEN		374. SIGNATURE OF SOLDIER		375. SIGNATURE OF SEAMAN	
376. SIGNATURE OF AIRMAN		377. SIGNATURE OF MARINE		378. SIGNATURE OF NAVY		379. SIGNATURE OF AIR FORCE		380. SIGNATURE OF MARINE CORPS	
381. SIGNATURE OF COAST GUARD		382. SIGNATURE OF NATIONAL GUARD		383. SIGNATURE OF RESERVE		384. SIGNATURE OF MILITIA		385. SIGNATURE OF VOLUNTEER	
386. SIGNATURE OF CITIZEN		387. SIGNATURE OF SOLDIER		388. SIGNATURE OF SEAMAN		389. SIGNATURE OF AIRMAN		390. SIGNATURE OF MARINE	
391. SIGNATURE OF NAVY		392. SIGNATURE OF AIR FORCE		393. SIGNATURE OF MARINE CORPS		394. SIGNATURE OF COAST GUARD		395. SIGNATURE OF NATIONAL GUARD	
396. SIGNATURE OF RESERVE		397. SIGNATURE OF MILITIA		398. SIGNATURE OF VOLUNTEER		399. SIGNATURE OF CITIZEN		400. SIGNATURE OF SOLDIER	
401. SIGNATURE OF SEAMAN		402. SIGNATURE OF AIRMAN		403. SIGNATURE OF MARINE		404. SIGNATURE OF NAVY		405. SIGNATURE OF AIR FORCE	
406. SIGNATURE OF MARINE CORPS		407. SIGNATURE OF COAST GUARD		408. SIGNATURE OF NATIONAL GUARD		409. SIGNATURE OF RESERVE		410. SIGNATURE OF MILITIA	
411. SIGNATURE OF VOLUNTEER		412. SIGNATURE OF CITIZEN		413. SIGNATURE OF SOLDIER		414. SIGNATURE OF SEAMAN		415. SIGNATURE OF AIRMAN	
416. SIGNATURE OF MARINE		417. SIGNATURE OF NAVY		418. SIGNATURE OF AIR FORCE		419. SIGNATURE OF MARINE CORPS		420. SIGNATURE OF COAST GUARD	
421. SIGNATURE OF NATIONAL GUARD		422. SIGNATURE OF RESERVE		423. SIGNATURE OF MILITIA		424. SIGNATURE OF VOLUNTEER		425. SIGNATURE OF CITIZEN	
426. SIGNATURE OF SOLDIER		427. SIGNATURE OF SEAMAN		428. SIGNATURE OF AIRMAN		429. SIGNATURE OF MARINE		430. SIGNATURE OF NAVY	
431. SIGNATURE OF AIR FORCE		432. SIGNATURE OF MARINE CORPS		433. SIGNATURE OF COAST GUARD		434. SIGNATURE OF NATIONAL GUARD		435. SIGNATURE OF RESERVE	
436. SIGNATURE OF MILITIA		437. SIGNATURE OF VOLUNTEER		438. SIGNATURE OF CITIZEN		439. SIGNATURE OF SOLDIER		440. SIGNATURE OF SEAMAN	
441. SIGNATURE OF AIRMAN		442. SIGNATURE OF MARINE		443. SIGNATURE OF NAVY		444. SIGNATURE OF AIR FORCE		445. SIGNATURE OF MARINE CORPS	
446. SIGNATURE OF COAST GUARD		447. SIGNATURE OF NATIONAL GUARD		448. SIGNATURE OF RESERVE		449. SIGNATURE OF MILITIA		450. SIGNATURE OF VOLUNTEER	
451. SIGNATURE OF CITIZEN		452. SIGNATURE OF SOLDIER		453. SIGNATURE OF SEAMAN		454. SIGNATURE OF AIRMAN		455. SIGNATURE OF MARINE	
456. SIGNATURE OF NAVY		457. SIGNATURE OF AIR FORCE		458. SIGNATURE OF MARINE CORPS		459. SIGNATURE OF COAST GUARD		460. SIGNATURE OF NATIONAL GUARD	
461. SIGNATURE OF RESERVE		462. SIGNATURE OF MILITIA		463. SIGNATURE OF VOLUNTEER		464. SIGNATURE OF CITIZEN		465. SIGNATURE OF SOLDIER	
466. SIGNATURE OF SEAMAN		467. SIGNATURE OF AIRMAN		468. SIGNATURE OF MARINE		469. SIGNATURE OF NAVY		470. SIGNATURE OF AIR FORCE	
471. SIGNATURE OF MARINE CORPS		472. SIGNATURE OF COAST GUARD		473. SIGNATURE OF NATIONAL GUARD		474. SIGNATURE OF RESERVE		475. SIGNATURE OF MILITIA	
476. SIGNATURE OF VOLUNTEER		477. SIGNATURE OF CITIZEN		478. SIGNATURE OF SOLDIER		479. SIGNATURE OF SEAMAN		480. SIGNATURE OF AIRMAN	
481. SIGNATURE OF MARINE		482. SIGNATURE OF NAVY		483. SIGNATURE OF AIR FORCE		484. SIGNATURE OF MARINE CORPS		485. SIGNATURE OF COAST GUARD	
486. SIGNATURE OF NATIONAL GUARD		487. SIGNATURE OF RESERVE		488. SIGNATURE OF MILITIA		489. SIGNATURE OF VOLUNTEER		490. SIGNATURE OF CITIZEN	
491. SIGNATURE OF SOLDIER		492. SIGNATURE OF SEAMAN		493. SIGNATURE OF AIRMAN		494. SIGNATURE OF MARINE		495. SIGNATURE OF NAVY	
496. SIGNATURE OF AIR FORCE		497. SIGNATURE OF MARINE CORPS		498. SIGNATURE OF COAST GUARD		499. SIGNATURE OF NATIONAL GUARD		500. SIGNATURE OF RESERVE	

Don. 18, 1938

13212

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13228

Film G 239 item 3 3/2/59 gg

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN lb 55 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 828 Lafayette Avenue			d. STREET ADDRESS 828 Lafayette Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Edward Wilson Warnick			4. DATE OF DEATH Month Dec. Day 8 Year 19 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 16, 1895		9. AGE (In years last birthday) 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Brewing Co.		11. BIRTHPLACE (State or foreign country) Somerset, Pa.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME David L. Warnick			14. MOTHER'S MAIDEN NAME Martha Ohler		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes War I		16. SOCIAL SECURITY NO. 214-05-4922		17. INFORMANT Address Mrs. Elizabeth Scott, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Sclerosis (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Dec. 8, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-11-58		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
				22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.			24a. REC'D BY REGISTRAR DEC 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Howard

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13227

13211 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT ASHBY 85 X - 3	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First NORMAN Middle V. Last WAGONER		4. DATE OF DEATH Month DECEMBER Day 28 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 13, 1881
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self Emp.	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA Springfield		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME NORMAN WAGONER		14. MOTHER'S MAIDEN NAME Jane RICE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 723-09-0967A	
17. INFORMANT MEMORIAL HOSPITAL		Address - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage with no complications 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive and arteriosclerotic DUE TO (c) Arteriosclerotic		INTERVAL BETWEEN ONSET AND DEATH 25 Dec. 58	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 25 Dec. , 19 58 to 28 Dec. , 19 58 , that I last saw the deceased alive on 28 Dec. , 19 58 , and that death occurred at 4:15 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. Alfred Van Ormer M.D.		ADDRESS (Street, city or town, state) 177 S. Centre St. Cumberland, Md.	
DATE SIGNED 28 Dec 58			
PHYSICIAN'S NAME (Type) DR. W. ALFRED VAN ORMER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-31-58	
22c. NAME OF CEMETERY OR CREMATORY Hill Cemetery		22d. LOCATION (City, town, or county) (State) Springfield, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DEC 30 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

13213 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b 13 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland d. STREET ADDRESS 322 Holland St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frank Joseph Weisenmiller		4. DATE OF DEATH Month Dec. Day 4 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/29/92
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steamfitter (retired)		10b. KIND OF BUSINESS OR INDUSTRY Plumbing	
11. BIRTHPLACE (State or foreign country) Maryland, Cumberland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Weisenmiller (deceased)		14. MOTHER'S MAIDEN NAME Eleanor Yupia	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 214-05-7969	
17. INFORMANT Mrs. Margaret Weisenmiller		Address Cumberland, Md. 322 Holland St.,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 518X Empyema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/20 , 19 58 , to 12/4 , 19 58 , that I last saw the deceased alive on 12/4 , 19 58 , and that death occurred at 6:05A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 456 N. Centre St., Cumberland, Md. DATE SIGNED 12/4/58 ACTUAL SIGNATURE Leo H. Ley, Jr. M.D. PHYSICIAN'S NAME (Type) Leo H. Ley, Jr., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/6/58	22c. NAME OF CEMETERY OR CREMATORY S. S. Peter & Paul's	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		24a. REC'D BY REGISTRAR DATE DEC 8 '58	24b. REGISTRAR'S SIGNATURE Arthur L. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1918 CERTIFICATE OF DEATH

Name of deceased		Sex		Age	
Date of birth		Place of birth		Usual residence	
Cause of death		Duration of illness		Time of death	
Place of death		Occupation		Marital status	
Signature of physician		Signature of registrar		Signature of informant	
Date of registration		Place of registration		County	
State		City		Town	
Zip		County		State	
Registrar's name		Registrar's address		Registrar's phone	
Registrar's signature		Registrar's seal		Registrar's stamp	
Registrar's date		Registrar's place		Registrar's county	
Registrar's state		Registrar's city		Registrar's town	
Registrar's zip		Registrar's county		Registrar's state	
Registrar's name		Registrar's address		Registrar's phone	
Registrar's signature		Registrar's seal		Registrar's stamp	
Registrar's date		Registrar's place		Registrar's county	
Registrar's state		Registrar's city		Registrar's town	
Registrar's zip		Registrar's county		Registrar's state	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13214 CERTIFICATE OF DEATH

13230

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. LENGTH OF STAY IN 1b 1 DAY	
d. NAME OF HOSPITAL (If not in hospital, write name of address, OR INSTITUTION) WARRICK MEMORIAL HOSPITAL AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DANIAL Middle S Last WHITACRE		4. DATE OF DEATH Month DECEMBER Day 10 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 7, 1958
9. AGE (In years last birthday) yrs. 7		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM WHITACRE		14. MOTHER'S MAIDEN NAME MERRY COLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Failure 7545 DUE TO (b) Dehydration + Malnutrition Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Enlarged Heart (Congenital). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 hours 4 Months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-9- , 19 58 , to 12-10 , 19 58 , that I last saw the deceased alive on 12-10 , 19 58 , and that death occurred at 5:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. H. W. Eliason		ADDRESS (Street, city or town, state) 1267 Union St. Cumberland Md	
PHYSICIAN'S NAME (Type) DR. H. W. ELIASON		DATE SIGNED 12/11/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-12-58	
22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md	
24a. REC'D BY REGISTRAR DEC 15 '58		24b. REGISTRAR'S SIGNATURE Christina S. Kraus	

13215 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 24 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 223 Massachusetts Avenue			d. STREET ADDRESS 223 Massachusetts Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Margaret Middle A Last Whitson			4. DATE OF DEATH Month December Day 7 Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 19, 1870		9. AGE (In years lost birthday) 88 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Lucas Appel		
14. MOTHER'S MAIDEN NAME Sarah Ann Miller			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. None			17. INFORMANT Roy Whitson Cumberland Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 <i>Arterio Sclerotic Cardia</i> DUE TO (b) <i>Vascular disease</i> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					INTERVAL BETWEEN ONSET AND DEATH ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from Dec 3, 1958 , to Dec 5, 1958 , that I last saw the deceased alive on Dec 5, 1958 , and that death occurred at 7:30 P. M. , from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Ruth E. Silcox</i>		ADDRESS (Street, city or town, state) Cumberland Md		DATE SIGNED 12/8/58	
PHYSICIAN'S NAME (Type) _____					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/10/58		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
22d. LOCATION (City, town, or county) Baltimore		(State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox			ADDRESS Cumberland Maryland		
24a. REC'D BY REGISTRAR DEC 10 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thorne</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		65		M		W		1854		NEW YORK		NEW YORK		UNITED STATES	
RESIDENCE		DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
NEW YORK		JAN 10 1915		10:30 AM		NEW YORK		NEW YORK		UNITED STATES		HEART DISEASE		NATURAL	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		WIDOW		DIVORCED	
Carpenter		8 Years		Roman Catholic		Married		Yes		No		No		No	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH	
JAMES H. HARRIS		MARY J. HARRIS		Carpenter		Homemaker		New York		New York		1849		1851	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH	
FATHER'S SIGNATURE		MOTHER'S SIGNATURE		DECEASED'S SIGNATURE		WITNESSES' SIGNATURE		MINISTER'S SIGNATURE		REGISTRAR'S SIGNATURE		DATE OF REGISTRATION		PLACE OF REGISTRATION	
JAMES H. HARRIS		MARY J. HARRIS		JAMES H. HARRIS		JOHN J. HARRIS		JOHN J. HARRIS		JOHN J. HARRIS		JAN 10 1915		NEW YORK	

1915

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. WHITWORTH MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13232

13216 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE MARYLAND WEST VA. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROMNEY 85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVENUE				d. STREET ADDRESS 431 N. FULTON ST.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First BABY GIRL Middle WOLFORD Last WOLFORD				4. DATE OF DEATH Month DECEMBER Day 22 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-21-58	
9. AGE (In years last birthday) yrs. 22				IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME WILLIAM WOLFORD				14. MOTHER'S MAIDEN NAME SUE E. BERRY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT MEMORIAL HOSPITAL Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776x Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 776x DUE TO (c) 776x INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 Month, Day, Year p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Romney				20g. (County) W. Va.		20h. (State) W. Va.	
21. I certify that I attended the deceased from 12-21-58 to 12-22-58 , that I last saw the deceased alive on 12-22-58 , and that death occurred at 10:25 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Fuller P. Whitworth				ADDRESS (Street, city or town, state) Cumberland Md			
PHYSICIAN'S NAME (Type) DR. FULLER P. WHITWORTH				DATE SIGNED 27 Dec 58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 23, 1958		22c. NAME OF CEMETERY OR CREMATORY Indian Mound Cem.		22d. LOCATION (City, town, or county) (State) Romney W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Reed Hoffa ADDRESS Romney W. Va.				24a. REC'D BY REGISTRAR JAN 6 1959		24b. REGISTRAR'S SIGNATURE Arthur E. Hume	
